PUBLIC HEALTH NURSING

MAY
1949

■ CHILD AND FAMILY
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■ NURSE MIDWIFERY
A Committe Report

■ RECENT DEVELOPMENTS IN DRUG THERAPY
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PUBLIC HEALTH NURSING

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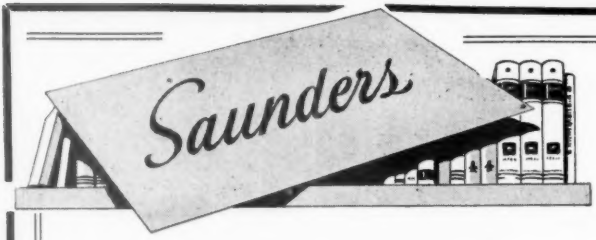

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The National Organization for Public Health Nursing is a membership organization composed of individual and agency members. Its purpose is to serve as a clearing house of information, and to develop and interpret standards for personnel and practices in public health nursing. This is accomplished through an advisory service to individuals and agencies interested in public health nursing; through publications, including the official magazine PUBLIC HEALTH NURSING, and through connections with national, state, and local agencies in related fields. The organization is administered by an elected board of lay and professional members. Its activities are carried on by committees representing public health nursing and related fields, and by an employed staff.

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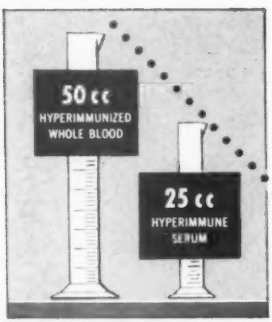

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PUBLIC HEALTH NURSING

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MIDCENTURY CHILDREN

As May Day, Child Health Day, comes again, our thoughts naturally turn to children. Indeed there has never been a time when more thought has been given to planning for children. Nor has there ever been a time when children more needed our soundly laid plans, translated into hard, fast action. All about us are pressures. We are pushed and pulled physically and emotionally. Peace, for which the world battled, seems far away. Nations are faced with disorganization, and families with ever growing frustrations. If the world ever is to be a safer, happier place, if society ever is to realize the promises implicit in technological, scientific, and sociological gains, it will be because the next generation of children will grow up to make it possible. It follows that every member of society, every family member, and particularly every professional person in the maternal and child health field must do all he can to help assure these future adults, on whom so much depends, a good childhood.

The maternal and child health section of the National Health Assembly stated: "The overall goal toward which we are working is to assure every child the experiences in life which will result in his attaining adulthood fully mature and healthy in body and mind, emotionally secure, able to give more than is asked for, to face success and frustration with equanimity, to be self-reliant, to cooperate with his fellows, to take his place in a democratic society as a thoughtful responsible citizen concerned with the common good."

Undoubtedly child rearing has been the family's most important function throughout history. Yet parenthood, about which such enthusiastic eulogies are written, is filled with stresses and strains. The joys of parenthood can be overbalanced by its daily worries.

In our American culture mothers have carried almost the complete responsibility for child care and guidance. The omission of the father from the parent-child concept has been hard on both child and father. The father-child relationship should be just as real, just as close, as the mother-child relationship. At long last the American father is showing that he can take his place in the parenthood team and we must see that he has opportunity for meeting his responsibilities.

There is nothing new in the words parent education but there is a crying need for new emphases, new approaches, new direction in parent education. This of course is not a field primarily for physicians and nurses alone. Many other groups are making distinguished contributions to parent education, especially along experimental lines. Few of these, however, have the opportunity to see families as intimately or over as long periods of time as do public health nurses. Nurses need to be familiar with variations in the different schools of child psychology so they can clarify and reinforce parents' understanding of the guidance given them by their physicians. Parents are reading books by child care experts voraciously. They attend lectures in droves. They join study groups avidly. They are exposed to a terrifying amount of conflicting advice. There are as many pitfalls in the new ways of child guidance as in the old, and possibly because they are less obvious, the nurse who undertakes parent instruction must know what she is doing as never before. We

must be sure that the help we offer will not confuse and thus tend to add further tensions to family life.

"If health workers conduct themselves in their contacts with patients in such a way as to increase anxiety they are adding to the burden of corrective care that someone must carry later on. If they conduct themselves so as to relieve anxiety and build up a patient's inner security they are perhaps doing more for the mental health of the community than they can do in any other way. To help young mothers in ten blocks of a housing project to bring up their babies naturally, happily, and easily, is certainly as valuable a contribution to the mental health of the community as the rehabilitation of ten neurotic children." Thus, Geddes Smith in *Human Relations in Public Health*, sums up potentialities in this field.

The challenges facing the professional worker today are endless. One of these is that she strive to keep up with the trends and developments in the area of her skills. For the nurse working with family groups it is not enough that she be proficient in the fields of maternal and child care—though this is basic. It is also important that she know what related groups in the medical and social sciences, education, and even anthropology are studying and initiating.

The study of the American Academy of Pediatrics now released to the public is an example. This contains a wealth of source material around which in-service education programs may be developed. Review of studies of this type will prove valuable in enlarging one's point of view.

The Expert Committee on Maternal and Child Health of the World Health Organization is another group studying the needs of children—on a global scale. They met in January to map out plans for a variety of services to many countries.

Plans for the Midcentury White House Conference on Children, which will be held late in 1950, are now well under way. Many of the states have set up councils or committees for children and youth. These are the groups doing the spadework for the Midcentury Conference. They will not only study unmet needs, appraise local and state programs, and agree upon a program for the Conference, but also will speed accomplishment in the field of child welfare as fast and completely as possible before the 1950 Conference. These local groups offer opportunities to participate in the planning and action programs which will be carried out. Nurses as working partners will be welcomed by these groups and cannot afford to remain outside.

MARY ROBERTS RETIRES

Announcement has been made of the retirement of Mary M. Roberts as editor-in-chief of the *American Journal of Nursing*. Miss Roberts has been with the Journal for 28 years and is known to many thousands of nurses throughout the world. She has wielded a pen of great power for the improvement of nursing education and nursing service. Ruth W. Hubbard, president of NOPHN, has said, "Miss Roberts' contribution to the Journal, and through it to all of nursing, has been so consistently distinguished that we shall long enjoy the benefit of her leadership, even while we miss her personal direction of the Journal."

Miss Roberts has always been gracious and willing in sharing her wisdom and experience with our own magazine. We are grateful she has promised to continue her friendship.

MENTAL HEALTH IN WHO

For the first time mental health will be included in the program of the World Health Organization, if the recommendations proposed by the Executive Board are passed on favorably at the WHO Rome Assembly on June 13, 1949. As a founder of the World Federation for Mental Health which developed out of the 1948 International Congress on Mental Health in London, the NOPHN is ac-

(Continued on page 269)

PUBLIC HEALTH NURSE IN AN OBSTETRICAL CLINIC

FRANCES BOYLE, R.N.

THIS IS an exciting era in obstetrics with the new phrases "childbirth without fear," "painless childbirth," "natural childbirth," "relaxation exercises," "rooming-in," "self-demand feeding," and "early ambulation." These phrases have brought about a revolution in our own ideas in relation to obstetrical care. Also they have acted as a stimulus in our educational efforts in this field, especially as they relate to patients and their understanding of present-day maternity care. We have the patient who is pregnant for the first time, and the patient that may have faced entirely different management in her last pregnancy. She will need encouragement and guidance as much as the primipara. This implies that the nurse must spend more time in interpretation and assist with the patient's adjustment to the new ideas about her care.

The major objective in any obstetrical program is a physically and emotionally well mother with a healthy baby. The preventive and corrective opportunities that come with early registration of pregnant women allow for the success of this objective. Early registration implies that the woman seeks medical care after her second menstrual period has lapsed. It is customary that a complete physical examination will be done, which should include a pelvic with measurements unless there is a history of spontaneous abortions, bleeding, or other contra-indications. Here a chest x-ray is done, complete blood examination for Wassermann reaction, Rh factor, and hemoglobin, urine analysis for sugar and albumin, and vaginal smears if indicated. X-ray pelvimetry will be done near or at term when cephalopelvic disproportion is suspected, or in elderly primigravida, history of previous Caeserian sections, and excessive weight gain. We are placing special emphasis on nutrition, oral prophylaxis, general hygiene, and a positive approach to the total well-being of each prospective mother. This summarizes the picture of thoughtful care that is possible for every clinic patient.

Since this paper is about the public health nurse, discussion will be confined to the part that she takes and some of the ways she tries to function.

In the clinic the patients register, on an average, when they are 12 to 14 weeks pregnant, which gives the nurse an opportunity to listen to the early reactions expressed about the pregnancy. Even when it is a wanted experience the first reaction seems to be "Oh! Dear," or "I had so many things planned and now I am pregnant." From observation it would appear that the truly happy women have accepted the fact of pregnancy by the time the second menstrual period is due. However a large number of women are beset by fear, anger, anxiety, and discontent. These factors are often mani-

Miss Boyle is supervisor and instructor in the out-patient clinic in obstetrics and gynecology at Cornell University-New York Hospital, New York City.

fested by ptyalism, nausea, vomiting, or obscure complaints for which no physical basis can be found. Dr. Grantly Dick Read gives us this thought, "Childbirth is not an acquired habit, it is the fundamental law of nature." Since this is a true statement we might try to understand some of these behavior factors as observed in the clinic and how some of them are interpreted.

ANXIETY! Today more women are employed outside of their homes and there is definite concern over the change in the economic status, housing or living conditions which precludes the acceptance of a baby, lack of adequate facilities for the proper care of this new life, and apprehension in relation to the husband's attitude. His attitude seems to color the total experience. He may not want the responsibility of parenthood; he may be jealous of the idea of sharing love of his wife with the baby; he may feel it is too early in their life together; or as in a few instances, be delighted and make the pregnancy a working and sharing together situation. One young woman said, "My husband has his mind set on a boy, I do so hope it will be a boy." The nurse took this opportunity to discuss sex determination and to send some literature home for the prospective father.

Fear! The young pregnant woman seldom hears about the normal happy pregnancy. Usually she hears only about the abnormal happenings that end in prolonged labors, death, or loss of the baby. The first examination may be delayed for this reason. Recently after her examination a young woman smiled at the nurse and said, "That was not so bad as I had been told it would be." Another approached the nurse with this statement, "I am so afraid." This was an opportunity to show pictures of the baby in utero and to discuss the growth and development of the baby, the function of the cord, and to give reassurance that the mother was found to be doing well at this time. She sighed and thanked the nurse, but the amount of reassurance that was given would only carry over for a time, with repetition necessary as she approaches her delivery.

Discontent! This is usually apparent in the older age group where there are other children in the family, or when the mother thought her days for having babies were over. Then the reactions are, "I do not want this baby," "We cannot afford this baby," or "I have three babies and I am only twenty-four," "I am tied down, we never go anywhere," and "I am too old to start all over again." This leads to the age-old problem of planned families, not that planned-for children are any happier, but usually they are wanted children.

Anger! These are the women who blame their husbands for the pregnancy. They imply that it was against their desires and wishes, or that he would not take "care of me." This indicates that many of our prospective parents do not have an understanding of the art of love and happiness. We are trying through individual conferences, suggested reading, and informal classes for husband and wife to increase their understanding of each other.

In relation to fear, doctors and nurses are often the greatest offenders, for they fail to recognize the mechanism of the woman's imagination. How to reassure is always an individual problem, but interpretation of words, explanation of findings at the time of the examination will do much to allay their worry. "Floating," a word used in the early months of the pregnancy, leads to this story. A young woman left the clinic after hearing that word and two days later her husband called to ascertain what his wife had been told on the last clinic visit. The record did not convey anything unusual. Then he said, "What does floating mean?" In the continued discussion it was revealed that his wife thought that the head had become detached from the body of her baby.

"Engagement" makes me think of a recent experience. A young woman was pregnant for the first time. She had a rachitic pelvis and was considered to be an obstetrical problem. She was watched carefully and as time for her delivery approached the examination revealed that the baby was engaged. The doctor turned to the group and said, "Well, boys she's engaged." Before he could say another word

she sat up and said, "Oh! Doctor, I am more than engaged, I am married."

Ignorance is another factor, neither parent understands the normal natural processes that accompany the growth and maturation of the infant. The birth of the baby may loom as an ordeal to be gone through. Such questions arise, as "Will I have a normal delivery?" "Can I try natural childbirth?" "How will I know it is time to come to the hospital?" A frantic telephone call the other morning came asking for an appointment for the "sex determination clinic." When it was explained that we did not know of any such service the voice said, "But you must have."

THE ABILITY to listen without showing one's own emotion to any statement made by the patient is necessary. One of our patients had a poor preparation for marriage and parenthood. Her parents were divorced when she was 12 years old. She married a conscientious objector at the age of 19 and he was in camp throughout this pregnancy, while she lived alone. She failed to carry out suggestions in relation to her own or the coming baby's care. One morning she appeared and sat down by the desk. Literally she kicked up her heels and said, "I hate this thing growing inside of me." The nurse listened and quietly said, "I am not surprised." A look of wonder passed over the girl's face, she straightened and said, "I did not expect that." A careful and complete discussion followed with the aid of pictures and an explanation of what was happening within her body. The further responsibility of the baby's needs were considered. Her reaction was marked and though she had only about six weeks before the expected date of confinement, she settled down and tried to follow advice. While she was in the hospital the nurses reported that she was a model mother and she successfully nursed her baby.

Sex education is another facet in this field of opportunity. Preparation of the other members of the family for the arrival of the new baby is necessary. In conferences with the multipara you are apt to hear such statements as, "My child is too innocent," "My son is twelve and he was so jealous last time that I cannot tell him now—he was seven when the last baby was born," "My sixteen-year-old daughter will not speak to me since I told her." In watching patients being discharged from the hospital one is constantly reminded of the need that little children have to share and to be a part of this experience long before the actual arrival of the new brother or sister.

Our plan also includes the postpartal examination. All patients are given an appointment for their six-weeks examination and about 90 percent do return. At this time we are able to interview all mothers. We discuss the medical findings, instruct in the proper technic of douching, and check on the type of feeding. We encourage their attendance at a well baby service and ascertain if they have received their birth certificates for this baby. Most of the questions relate to themselves; when will the normal menstrual period return? when can I take a tub bath? can I lose weight now? Then as we express interest in the baby the usual statements center around sleep, feeding, formula making, and the attitude of the other members in the family.

Mothers' classes are attended primarily by the primipara. We do invite the multipara but often she cannot attend regularly because of home responsibilities. We have seven meetings held once a week outside of regular clinic time, which means that the mothers have to make another trip to the class. Content is built around what the mothers already know about pregnancy and around anatomy and physiology of the reproductive system. Nutrition for the family is given by a nutritionist. Other topics are preparation for delivery and hospital admission, baby bath demonstration and equipment, discussion of the newborn given by a pediatrician, and taking the baby home with plans for fitting it into the family.

Fathers' classes are conducted separately with the assistance of the resident of the antepartal service. We have a series of five meetings held in the evening once a week. There is discussion of the responsibility of fatherhood, the need for sharing in this new experience, the art of love, anatomy and

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group. This material includes statistics on maternal and infant mortality, with each student bringing statistics from her own area and describing some of the problems in her own state. Complications of pregnancy are discussed and the legislative measures that have been passed to control and prevent future unhappiness. Antepartal nursing is considered with thought given to the changes that pregnancy necessitates in the woman and in the family. Home delivery service with a brief outline of what is essential for a safe aseptic delivery is a further topic. All of our students have an opportunity to visit the Maternity Center School of Nurse Midwifery. The next unit is devoted to discussion of group teaching, equipment, personnel, place for meetings, homogeneity of the group and content.

Considerable interest is focused upon the leader. She should be a good hostess; she should inspire confidence and have a pleasant voice. She must be able to recognize the individual within the group. She should be familiar with her subject matter, use language that the group will understand, allow time for questions. And she should be able to draw out responses.

ANOTHER PHASE of this program is the integration within the obstetrical service which makes total patient care more interesting. Meetings with the supervisors of the in-patient service occur bi-monthly and individual patients, and students are discussed in relation to progress and possible adjustment for the betterment of service or care. This case will illustrate the close working relationship that exists:

Mrs. A, a cardiac, was advised by the clinic doctor to accept hospitalization in the fifth month of this pregnancy. Since she refused, she was referred to the nurse and with much effort it was discovered that she could not bear to leave her 18-month-old daughter, "She is so cute and I do not want to miss a day with her." After ascertaining that it was not the financial cost but only the separation from her child which was the stumbling block, a plan was worked out in consultation with the in-patient service whereby the mother could see her child weekly. When Mrs. A was informed of this plan she came in for care and gave birth to another lovely baby.

Still another case is demonstrated by Mrs. K who has light perception but comes under the blind classification. She was most anxious to care for her own baby but was so tense and apprehensive that not much was accomplished by the clinic visits. She attended mothers' class and during bath demonstration stood over the table and felt all the equipment, but this was not enough to give her the much needed security. We went to the in-patient supervisors and discussed the problem. A plan evolved that would permit her to handle and care for her baby more than the average patient. She delivered a lovely little girl and went home happier and more secure although the nursery nurses were a little apprehensive. She was referred to the Visiting Nurse Service for continued guidance.

The inter-agency referral system is also a part of the total patient care program in the obstetrical clinic. All the primigravida are routinely referred to the Visiting Nurse Service. The public health nurse makes contact with these women individually or through their mother's classes. Reports are returned to the hospital and become a part of the total record. This process strengthens the hospital personnel's understanding of the home situation and increases the interest of all workers in the individual patient. All of this may be very familiar to the readers. It is vital and necessary and we hope that more obstetrical services will arrange for continuous nursing care and direction for the patients in and out of the hospital.

Yes, it is not only the new discoveries and procedures that make this an exciting era in obstetrics. No other service offers such opportunities for affecting family life and happiness. The challenge itself is worth all our efforts.

SOME RECENT DEVELOPMENTS IN DRUG THERAPY

ELIZABETH S. GILL, R.N.

YEARS AGO Pasteur said, "It is within the power of man to wipe infectious diseases from the face of the earth." This we have not yet accomplished. However, recent years have added potent ammunition to our armament to fight the common enemies—disease, pain, and uncleanliness. Perhaps the greatest contributions have been in the field of chemotherapy and antibiotics.

Very little has been added to the sulfonamide group of drugs and we feel we know them very thoroughly, their potentialities, and their weaknesses. Although they have not outlived their usefulness, they have largely been replaced by antibiotics.

THE ANTIBIOTICS

Penicillin, one of the earliest antibiotics to come into general use, has undergone some changes because we understand more about its chemical nature, its purification, and its potentialities. The greatest change has been in the matter of dosage. The blame for many of the earlier seeming failures of penicillin therapy had been laid at the door of inadequate dosage. The present tendency is to give larger doses less frequently. A new method of incorporating penicillin and procaine to delay its absorption and prolong its action makes this possible. Two preparations incorporating this principle are on the market under the proprietary names of "Duracillin" and "Crysticillin." Duracillin has been incorporated with *oil* and has procaine added to it. It is administered intramuscularly every 12-24 hours in doses of 300,000 or more units. Crysticillin is penicillin with procaine to be dissolved in distilled water and administered in the same manner as Duracillin. Of course, the severity of the infection and the response of the patient influences the size and frequency of the dose of any of the antibiotics. As with the aqueous solutions, sensitivity is characterized by fever, chills, and skin rash. It is still felt that oral administration of penicillin is wasteful, as about five times the intramuscular dose is needed to ensure adequate absorption.

Bacitracin, isolated from a special strain of Bacillus subtilis is a valuable addition to our battery of agents to control infection, especially surgical infections. Its range of activity covers primarily the same organisms controlled by penicillin. However, it has proven most valuable in inhibiting organisms that have become resistant to penicillin and sulfonamides. At present it is used locally and also injected into furuncles and carbuncles. While its toxicity is deemed to be low, further studies are being made before its systemic administration becomes widespread.

Streptomycin has been a tremendous advance in antibiotic therapy, for it offers some important new features. Its chief inhibitory action is on certain gram-negative organisms

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untouched by either penicillin, bacitracin, or sulfonamides. It is the drug of choice in treating influenzal and tubercular meningitis, urinary infections caused by gram-negative organisms, tularemia, and several others. Attention now is focused on its place in the treatment of tuberculosis. It is showing much promise in this specialized field of therapy. Because of its toxicity when administered in large doses and over a long period of time, it is generally felt that persons with minimal and non-progressing lesions and those doing well with conservative therapy, are not candidates for streptomycin. The greatest drawbacks to the use of the drug are the rather rapid resistance of the organism to the drug and serious toxic effects to the eighth cranial nerve manifested by vertigo, tinnitus, and deafness—changes which may be irreversible.

To avoid these complications, a new modification, *Dihydrostreptomycin* has been introduced, which seems to show promise in making possible the continuance of the drug for the 60, 90, 120 or more days necessary for adequate tuberculosis treatment. Dosage of these drugs is frequently 1-2 grams in divided doses every six hours by the intramuscular route.

Another promising newcomer to the field of antibiotics is *aureomycin*. Like its predecessors, it has a wide range of activity. It seems to be bacteriostatic against the same organisms as is penicillin, and at the same time it makes its own added contribution in that it is our first anti-viral agent. It is showing great promise in the treatment of lymphogranuloma venereum, psittacosis, and virus pneumonia. Besides these virus diseases, it seems to be an effective means of treating typhus fever, Rocky Mountain spotted fever, staphylococcal eye infections, Q fever, rickettsialpox, and Brucellosis or undulant fever. The preferred channel of administration is oral, and the drug may be given in 250-500 milligram doses every six hours. Side-actions may be uncomfortable —nausea and vomiting and mild diarrhea, but actual toxicity seems to be low. Intramuscular injections tend to depress the bone marrow. On the whole, organisms show less tendency to become resistant to the drug. While its place in therapy has not been definitely established, it is a drug to watch with interest.

Other antibiotics are now under investigation, but it is still too early to predict their usefulness.

ANALGESICS

Progress has gone forward in developing the so-called "pain killers," chief among them the rather newly introduced group of synthetic morphine derivatives. We have long been aware of the problems presented by the use of morphine, both from the point of view of toxicity and the social problem of addiction. Science has been seeking a way to avoid both these difficulties, not with unqualified success. While the problem of addiction has not been solved, the newer agents tend to show less frequent addiction, less severe withdrawal symptoms, and withdrawal easier to control. The two newest drugs are *Methadon*, sometimes called *Dolophine*, and *Metapon*. Both these agents are deemed to have greater analgesic powers than either morphine or Demerol and their duration of effect is comparable to that of morphine. Tolerance develops slowly and disappears rapidly and addiction is more easily treated. Dizziness and nausea are the most frequently encountered side-effects. Respiratory depression rarely occurs. Both of these drugs have little sedative effect and are therefore somewhat unsatisfactory pre-anesthetic agents. A decided advantage of these drugs is their effectiveness by mouth, making them easy to use in caring for the patient in the home. Methadon is usually administered in doses of 2.5-10 milligrams and Metapon 6-9 milligrams. However, pain is an index to the amount of drug given.

Demerol or *Merperidine* has been an established drug for a considerable period of time. Unlike morphine, it tends to relax smooth muscle and is an effective antispasmodic as well as analgesic agent. A dose of 50-100 milligrams usually relieves pain as effectively as morphine, and at the same time exerts some sedative effect. Toxicity is low, and dry mouth and dizziness are the characteristic side-effects. Addiction sometimes occurs.

ALLERGY REMEDIES

Perhaps no greater annoyances have plagued the human race than allergies and

allergic phenomena. The development of anti-histamine drugs has afforded dramatic symptomatic relief, but has in no way affected the basic underlying problem of allergy. These drugs, in general, counteract the effect of the release of histamine or histamine-like substances seen in allergy. Two drugs widely used are *benadryl* and *pyribenzamine*. Both are used in 50 milligram doses, three or four times a day, although they can be safely administered in larger doses and more frequently if necessary. A note of caution should be sounded, however, regarding the careful use of sedative and narcotic drugs in conjunction with these agents. In many instances both of these drugs produce profound drowsiness although benadryl is the chief offender. Great relief has been afforded in alleviating allergic rhinitis and hayfever, pruritis and urticaria, contact dermatitis, and drug sensitivity. Results have perhaps been less convincing in bronchial asthma and migraine headache.

CARDIAC REMEDY

Since cardiac disease is still the major killer and crippler of human beings, it might be well to mention *digitoxin*, even though it is not particularly new. Digitoxin or digitaline-nativelle is a purified active principle of digitalis leaf. It has important advantages over digitalis leaf. In the first place, it is a pure substance and contains no irritating elements that may cause nausea and vomiting. Secondly, its dosage is determined by weight of the pure crystalline drug, is never variable, and avoids the confusion of determining dosage by units. A most important advantage is its rapid and complete absorption from the gastro-intestinal tract—its effects are seen as effectively and rapidly as with parenteral administration. The margin of safety is greater than when digitalis leaf is used, and in emergency the entire digitalization dose of 1.2-1.5 milligrams can be given in one dose, thus accomplishing digitalization within a short period of time. Digitalization may be obtained over a longer period of time by giving the drug in divided doses if that seems feasible. The daily maintenance dose is frequently between .1-.2 milligrams. Dosage is modified if the patient has already received or is susceptible to digitalis.

BLOOD AND BLOOD VESSELS

Folic acid has been of interest as a means of perhaps avoiding the disagreeable administration of liver extract in pernicious anemia. However, in the treatment of pernicious anemia it has proved disappointing in that it does not prevent, and even seems to enhance, the development of neurological manifestations, even when the blood picture has returned to normal. It is sometimes used as an adjunct to liver therapy, and has proven useful in treating sprue, pellagra, and other types of macrocytic anemias. It is of no value in other types of anemias. It is frequently given by mouth in 10-15 milligram doses.

For many years investigators have tried to isolate the active principle of liver extract with some disappointing results. However, with the isolation of Vitamin B_{12} believed to be this active anti-pernicious anemia principle, great promise is shown in the treatment of pernicious and other macrocytic anemias. While the exact dosage has not yet been determined, minute doses of 2-6 micrograms have been proven by several groups of investigators to have the ability not only to return the blood picture to normal, but also to prevent and alleviate the neurological changes that occur with pernicious anemia.

A drug that has been before the eye of the medical profession has been *Rutin*, a glycoside of vitamin P, which is responsible for maintaining the integrity of capillary walls. Its deficiency results in increased capillary fragility. Clinically, the drug has been investigated as a means of preventing retinal or cerebral hemorrhages in hypertensive states, and is given in doses of 25-50 milligram doses three times a day. Its place in therapy has not been definitely established.

Another important group of drugs, not entirely new, are the anticoagulants, or drugs that in some way delay the clotting of blood. These drugs are employed to prevent and to treat embolism and thrombo-phlebitis. While it is believed that these agents will have little effect on clots already formed, they will prevent the extension of these clots and the ap-

pearance of new clots. *Heparin*, an expensive substance, acts almost immediately and its effects last only three to four hours. It is administered either intravenously of subcutaneously, and the clotting time of the blood is carefully watched.

Dicumarol is an anti-coagulant administered orally in doses of .1-.2 gram. Unlike heparin, its effect is not seen for at least 48 hours. Anti-coagulant therapy is frequently instituted with the administration of heparin and dicumarol together,—heparin for its immediate effect and withdrawn as soon as the effect of dicumarol begins. Dicumarol is never administered unless there are facilities for frequent prothrombin determinations. Anti-coagulants have sometimes been used routinely in coronary occlusion as it is felt that both the disease and digitalis therapy tend to increase the clotting of blood.

IN DIETETIC DISEASE

Amino-acids are not new, but are very important. Lowered blood proteins often lead to difficulty in maintaining the water balance of the body, decreased resistance to infection, and a tendency for wounds to heal poorly. Amino-acids have been used most effectively in surgery, under-nutrition, diseases of the gastro-intestinal tract, kidney disease, cirrhosis of the liver, and anemia. They are frequently administered parenterally in amounts of 50-100 grams per day, but there is an increasing tendency to give them by mouth. It is felt that oral administration is psychically better and also permits a greater intake. It is certainly much cheaper and permits easy administration in the home. However, it takes some ingenuity and imagination to make them palatable.

Thiouracil has been used over a period of time in the preoperative treatment of hyperthyroidism. Its toxic effects have been serious, and recently a new, less toxic and more effective drug, *Propylthiouracil*, has been introduced. Like thiouracil, this drug interferes with the production of thyroxin.

Its effects are not immediately seen as it does not affect the stores of thyroxin already present, but only inhibits its further production. Dosage is usually instituted with 50 milligrams three or four times a day until the condition is controlled; then the dosage is decreased.

RADIO-ACTIVE SUBSTANCES

Atomic research has turned our attention to the use in medicine of several radio-active substances. The most extensively used are the radio-isotopes, radio-active phosphorous and radio-active iodine. These agents are available at low cost, but more clinical experience is needed to establish their therapeutic value. *Radio-active phosphorous* is used to treat polycythemia vera and also chronic myelogenous leukemia. Although the drug is not superior to radiation therapy, it has been found that with its use "radiation sickness" is avoided. Small repeated oral doses are given. Pressure symptoms of myelogenous leukemia may not be relieved to any extent, as the size of the liver and spleen is not as rapidly or as markedly reduced as with radiation. The drug has been disappointing in the treatment of Hodgkin's disease, acute leukemias, and lympho-sarcoma. Intravenous administration, dosage regulated by bone marrow response, may be used for three to seven treatments. Undesirable leukopenia or anemia may occur.

Radio-active iodine is used primarily for the treatment of carcinoma of the thyroid, and hyperthyroidism. Given orally in a single dose the drug seems to have an affinity for the thyroid gland and seems to achieve an "internal radiation." Toxicity is characterized by nausea and vomiting, fever, and general malaise.

TREATMENT OF METAL POISONS

An interesting drug emerged from World War II that has been turned to civilian use, *BAL*, (British Anti-lewisite) has proven useful in treating poisoning by various types of metals.

Introduced as an agent against lewisite gas containing arsenic, it has been effective in treating arsenical toxicity of antiluetic therapy, the toxicity of gold therapy, and possibly poisoning by bichloride of mercury. It is rather a troublesome drug to administer, and is prepared as a 10 percent solution in oil to be

given intramuscularly. The average dosage schedule is 3 milligrams per kilogram of body weight every four hours for two days; then four injections the third day, and two injections a day for ten days more or until recovery occurs. Toxic symptoms are usually transient,—malaise, nausea and vomiting, salivation, and lacrimation.

ANTI-MALARIAL DRUGS

Several anti-malarial drugs have been developed, and one of them, *Chloraquine,* is of particular interest because it seems to be of value in treating amoebic dysentery. It differs from other drugs for this purpose in that it not only destroys amoebae in the intestinal tract, but is also effective in involvement of the liver. Dangerous toxicity of treatment by emetine is thus avoided. Dosage is usually .3 gram twice a day for two days, then .2 gram for 12 to 19 days, repeating the course of treatment if necessary.

Medical science has made and is continuing to make a triumphal march of progress. Results of research have been almost incredible. They lead us to believe that problems that have ever defied solution will soon be conquered.

MESSAGE TO PARENTS

If Polio Hits Your Area This Year

Avoid crowds and new contacts in trains, buses or boats, if possible; avoid crowded places where you may be close to another's breath or cough.

Avoid over-fatigue, too active play, late hours, worry, irregular living schedules may invite a more serious form of the disease.

Avoid swimming in water which has not been declared *safe* by your health department.

Avoid chilling. Take off wet clothes and shoes at once. Keep dry shoes, sweaters, blankets and coats handy for sudden weather changes.

Keep clean. Wash hands after going to toilet and before eating. Keep food covered and free from flies and other insects. Burn or bury garbage not tightly covered. Avoid using another's pencil, handkerchief, utensil or food touched by soiled hands.

Quick Action May Prevent Crippling

Call Your Doctor at once if there are symptoms of headache, nausea, upset stomach, muscle soreness or stiffness, or unexplained fever.

Take His Advice if he orders hospital care; early diagnosis and prompt treatment are important and may prevent crippling.

Consult Your Chapter of the National Foundation for Infantile Paralysis for help. Your Chapter (see local telephone book or health department for address) is prepared to pay that part of the cost of care and treatment you cannot meet—including transportation, after-care, and such aids as wheel chairs, braces and other orthopedic equipment. This service is made possible by the March of Dimes.

Remember, facts fight fears. Half or more of those having the disease show no after-affects; another fourth recover with very slight crippling. A happy state of mind tends toward health and recovery. Don't let your anxiety or fear reach your children. Your confidence makes things easier for you and for others.

WHAT WE LEARNED FROM THE EMIC PROGRAM

RUTH G. TAYLOR, R.N.

EMIC draws to a close. As the dust of a spirited campaign settles, the troops of that campaign, physicians, dentists, nurses, administrators, can look back at what actually happened in order to consider what might have been done had they been able to prepare for it in advance. A year or two years, according to Dr. Nathan Sinai, who has directed a thorough study of the EMIC program, is not too long for the development of plans for reasonably adequate distribution of medical, nursing, hospital, and other health services. The EMIC program, however, had to be built in a day, figuratively speaking, and in the midst of our greatest national emergency—a mighty mobilization of men for war and a tremendous shifting of industrial and agricultural workers. Yet, a number of nurses who were involved in the EMIC program have said to me recently as we looked back at the EMIC experience, "Even under the 1943-45 conditions of haste and pressure, we could have done a better job than we did." Their frankness gave me courage to review that experience and to write down several points that seem significant to consider for the future if we are to succeed in providing more evenly distributed, more suitably selected, and better nursing services as an integrated part of any plan for medical care.

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WHAT IS EMIC?

First, so that all of us may have the same picture of EMIC in our minds, let me give you a description of it borrowed from a report by Dr. Martha Eliot, in March 1947:

> Four years ago Congress made the first appropriation for medical, nursing, and hospital maternity and infant care for wives and infants of enlisted men in the armed forces of the United States of the four lowest pay grades. In the next months, April 1943, plans for the operation of the EMIC program were approved by the Children's Bureau for 13 states, and within a year all 48 states, the District of Columbia, Alaska, Hawaii, and Puerto Rico were operating programs under approved plans. . . .
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> The primary purpose of the EMIC program was to raise the morale of enlisted men by relieving them of concern over the uncertainty of the availability of maternity care for their wives and medical and hospital care for their infants, and of anxiety as to how the cost of this care would be met. Under this program, enlisted men in the lowest pay grades know that their babies up to one year of age are entitled to all necessary medical, hospital, and nursing care. Furthermore, both maternity and infant care are given without a means test and irrespective of race, creed, or place of residence. . . .
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> The EMIC program has been administered from the beginning within the framework of Title V, Part I, of the Social Security Act, and operated with special funds made available by Congress to the Children's Bureau for grants to the state health agencies. The program in each state is operated by the state health agency under state plans approved by the chief of the Children's Bureau in accordance with general policies established by the Children's Bureau. Such national policies were necessary for this wartime program to assure as great a degree of uniformity in the availability of good care for the wives and infants of servicemen who were moving from state to state as was feasible under the conditions in the various states and communities in which they were living.

What problems did the size and the scope of this program raise for the nursing profession and those responsible for the administration of nursing services as an integral part of the total plan for medical care?

NURSES HELPED WITH OVERALL PLANNING

Nursing was represented immediately when the Children's Bureau began its planning for the program. Planning and policy-making in the Division of Health Services of the Children's Bureau is a "team" function of representatives of all professions on the staff. Besides almost daily participation in the drafting and redrafting of general policies on the basis of experience, nurses had five specific responsibilities:

1. Developing standards for nursing services in hospitals, maternity homes, and the patient's own home
2. Drafting regulations requiring referral of EMIC patients to local public health nursing services
3. Recommending professional policies regarding rates of payment for bedside nursing service
4. Drafting regulations for authorizing bedside nursing services paid for by the state health department
5. Developing display material showing samples of informational circulars, of forms for referrals and authorizations, and of contracts between official or voluntary agencies and graduate nurses as guides for state administrative agencies.

These responsibilities the nurses on the staff of the Children's Bureau carried out in close cooperation with a professional advisory committee representing the national nursing organizations. The Bureau's Nursing Unit and its advisors had to keep constantly in mind the limited amount of funds available for state administration of the EMIC program and the Children's Bureau's obligation to aid in conserving nursing service so that it would be fairly distributed to meet all needs of the civilian population during the war.

FIVE LESSONS THAT EMIC TAUGHT US

A detailed story of the growth of the various phases of the EMIC nursing program cannot be told in 20 minutes. I should like to focus on five lessons that we learned in our EMIC work that seem highly significant for the future:

1. *Providing Nursing Service.* Various plans were used by the state health agencies to obtain additional nursing service. In urban centers where bedside nursing service was not available from the health department, arrangements were worked out with visiting nurse associations for the provision of bedside care. The Red Cross provided similar care in many areas surrounding camps. Nation-wide insurance companies contributed the services of their local nurses. One or two state health agencies organized the graduate nurses in rural areas who agreed to serve in the program. Practical nurses who worked independently were not used because we had no way of determining their qualifications. When employed by visiting nurse associations they were included in the overall plan. I need not review with you the shortage in nursing personnel; this situation has changed very little since the end of the war.

A random sample of requests for nursing service from wives of service-men indicated a wide variation in the type of care required. In many instances help with the care of children and with housekeeping services might have been the most pressing need; in others a practical nurse could have supplied adequate care and in still others, of course, the need was for professional care. Our experience convinces us that for a complete medical-care program the whole range of services should be available in order that the various needs of individuals may be met as suitably and economically as possible and that professional service may be conserved. This means that those responsible for developing a medical care program have an obligation to see that the whole range of services is provided in the community and is made available to persons accepted under the program.

The original policy stated that *medical, hospital,* and *nursing* services would be provided to the wives and infants of servicemen in certain pay grades. Bulletins to state health agencies and instructions to physicians issued by the Children's Bureau as well as

notices enclosed with allowances to dependents of men in our fighting forces so as to reach the wives who were eligible for service all carried this information. Interpretations of "nursing services" that arose in the minds of health authorities, mothers eligible to the service, and men and women of the general public in all walks of life were almost as numerous as recipients of medical care. For example, take two requests made by letter, both showing the need for some supplementary service rather than maternity or pediatric nursing care: A serviceman writes, "Please send in a nurse, my mother-in-law has broken her leg." Another soldier writes, "My wife expects to go to the hospital tomorrow, please send a nurse to take care of the two young children." In other words, specific services should be developed to meet needs related in some way to maternity and infant care but not requiring special skills of a graduate nurse.

Various authorities have been predicting for some time that a shortage of nurses will exist for years to come. They tell us we must work out plans for use of both graduate and practical nurses in agency programs, the nurses in each group carefully assigned to appropriate duty. Fortunately, studies of the functions of graduate and practical nurses as well as of their distribution are being made in various parts of the country. These studies will be available before too long.

What was needed in the home where the mother-in-law had broken her leg was not a nurse for the injured woman but a worker to do what the mother-in-law had been doing to help the expectant mother—to take care of the children, do the marketing, cooking, cleaning, and other household tasks.

Communities have been slow to develop homemaker service sufficiently to meet the requirements for homemakers in all the public health and social agencies that need this service in their programs. Lately, however, the number of agencies providing the service has begun to increase rapidly. Most of the homemaker services in the country function in family or combined family and children's agencies. These agencies are generally privately supported, although public agencies are now showing much interest in developing these services.

Homemaker service provides workers trained to keep a household running smoothly for the children during their mother's temporary absence or incapacity. The homemaker's work is supervised by a qualified social caseworker who may also be working with the family on other problems besides those growing out of the mother's short or long-time inability to care for the children and to manage the household. The homemakers are usually staff members of the agencies, receiving the benefits that staff membership implies —a yearly salary related to the degree of responsibility the worker must assume, good working hours, and appropriate vacations. Generally the agencies provide some type of training. By arrangement made in advance, families pay the agency as much as they can afford for the service.

Recent reports from Australia show that the Commonwealth has housekeeping services for mothers during the maternity cycle. In one of the six states of Australia, the state provides funds for the service. The workers, usually called "home helps," are employed by social agencies organized for this purpose and paid at rates comparable to the pay received by women in industry and office work. The agency charges the family for the service, in full or in part according to the family's ability to pay.

We know from Finland that with the growth of public health nursing in that country the value of homemaking service has become more widely recognized. Public health nurses, with whom the homemakers work, feel they can do little for a mother who is ill or having a baby unless there is somebody to care for the household, the children, and perhaps the cattle and the garden. At present communities are required by law to have 1 public health nurse for each 4,000 of the population. A bill that would require this same proportion of trained homemakers in each community is now before Parliament. In practice that would mean a homemaker to each public health nurse on the staff.

Group instruction is another device for using our professional services more economi-

cally. This activity of nurses, particularly useful in maternal and child health services, should be further developed. Group instruction might have been carried on in cities and towns to good effect at the height of the EMIC program. It would have required careful community-wide planning and the selection of fully qualified instructors, skilled in meeting individual needs through a group approach. It would have required also a staff large enough to follow up in the home problems that could not be dealt with in an office or teaching center.

2. *Maintaining Quality of Care.* Tremendous advances were made in setting up methods for maintaining the quality of care during the operation of EMIC when state and local health agencies became concerned with the standards of care of mothers and infants in home or hospital. The advance was a contrast to lack of progress in methods of distributing personnel in sufficient numbers to supply adequate nursing service in a medical care program. This matter of distribution has not been explored thoroughly enough anywhere to provide us with broad conclusions or complete guides for future action in new programs or in the expansion of old ones.

In the EMIC program we were required to set up standards for personnel and facilities in an attempt to raise the quality of care throughout the patient experience to a minimum below which no service was allowed to fall. We discovered that the most effective way of maintaining or improving standards in nursing was to utilize qualified nurse consultants on the state agency staff who were equipped by education and experience to assume certain responsibility. They had to judge the quality of services available and to devise ways of improving them through advisory services to hospitals and health agencies.

Nursing specialists can work most effectively in a strong administrative structure in which they are given the opportunity to develop various phases of a program and maintain the quality of service. Completely secure in their knowledge of good maternity and infant care, they can be most effective if they are not required to assume responsibility for the general administration of nursing or for administrative duties concerned with programs that are not specifically related to the field of nursing.

3. *Organizing Nursing Service.* Four policies of the EMIC program broadened the scope of nursing in state health departments. The first is the responsibility EMIC gave to nursing to set up the qualifications of nurses and to participate in the formulation of hospital standards that were incorporated in the state plans. The second is the responsibility for organizing and using all available nursing power in the state for EMIC patients, regardless of agency affiliation. The third policy concerns the duty of inspecting and evaluating hospital services in maternity and infant care. The fourth involves handling the largest referral on record of maternity patients to local health agencies for public health nursing services.

The first item in policy, taking responsibility for setting up qualifications of nurses and standards for hospitals, brought the director of public health nursing into the hospital picture and the second item in policy focused her attention on methods of using all qualified nursing service available in the state in an integrated program for medical care. To carry out these responsibilities satisfactorily, she had to enter into the planning of the whole program at the time it was started. Her help was needed in establishing standards that might assure satisfactory nursing care in homes and hospitals and in setting up methods of establishing and maintaining these standards through the use of nurses as part of a team in the inspection of hospitals and maternity homes.

This inspection and consultation, skillfully carried out by a specialized maternal and child health consultant nurse, has since become an important permanent function of nursing service in many health departments. It has served to bring together the nurses from hospitals and health agencies for consideration of common problems and has resulted in significant improvement in hospital care of all maternity patients and infants. This greater unity gives promise of vast improvement in working out satisfactory continuity of care

for patients and promise of achieving the age-old need for "an adequate referral system."

In mobilizing all possible nursing care, nurses of the state health department were called upon to negotiate with other public health agencies, visiting nurse associations, school systems, and with individual graduate nurses for services that might be purchased under the provisions of the EMIC program. They were also called upon to negotiate for other nursing services that might be obtained without payment in order to assure as many mothers and infants as possible preventive as well as curative care.

A method of working together to make the most of nurse power and to appraise the capacity of all nursing agencies to meet the needs of one comprehensive nationwide program developed that sets a new starting line. In planning new programs or improving old ones on a statewide or local basis we are far ahead of our position in 1943. Those in charge of programs for the care of crippled children might well explore and develop further those methods of working together and might well do it right away. Services in crippled children's programs have the same range and afford the same opportunities for community or statewide organization that are envisioned or practiced in other medical care programs today.

Services for patients in rural areas require deep consideration. The trend in health department organization, seeming to be toward decentralization, that is, regional rather than statewide administration, may point to a possible solution of this problem. In a decentralized program, supervision of all services can be at a point easily accessible to all nurses taking part in the program. Registers of professional nurses may be used in urban areas to meet the increasing demands for bedside as well as for hospital nursing care. In rural areas, however, the demand for bedside care in homes may be too small to justify employing full time a corps of graduate and practical nurses. We must work out in these areas some way of assuring regular employment to nurses and auxiliary workers even though the volume of requests for home nursing service is unpredictable and professional registries are impracticable. Concerning the trend toward regional hospital service, employment of a corps of nurses and nurse's aides for work in the rural hospital, health center, and home might be the most effective way to assure adequate nursing service and also a continuity of care between hospital and home.

4. *Information About the Availability and Use of Services.* Nurses played a most important role in informing wives of servicemen of their rights to service under the EMIC program and in assisting them with their applications for service and their selection of physicians and hospitals. This activity, extremely helpful to patients, was also helpful to nurses. Close, positive contact with a large group of citizens benefited by EMIC made for a better understanding between those serving and those served that later resulted in wider and more effective community health services.

Much more significance should have been attached by professional nursing groups to one of the 13 conditions under which services were authorized by state health departments. The condition was stated in this way: "Individuals accepted for care under the program will be referred routinely to local public health agencies for the provision of public health nursing services that can be made available."

In other words, public health nursing was recognized, for the first time, as an essential service for all the patients eligible under a program of medical care. For the first time a large cross-section of the population of the United States received from nurses their first direct service from health departments. Unfortunately, local health agencies were generally too understaffed to provide this service designed for all patients authorized for care, regardless of economic status.

Informing local nurses of all maternity patients authorized for care in the EMIC program made it possible for them to develop working relations with many local physicians who formerly were unaware of their services. In one city a well organized public information program spread the details of the services so effectively that 125 physicians who had

not thought of using public health nurses began to refer patients from their regular practice who would benefit from this care.

5. *Policies Regarding Rates of Payment.* State and local associations working under the aegis of the American Nurses' Association have been accustomed to set the rate for hourly or daily services of graduate nurses and for their attendance during labor or delivery. They have set the rates according to the local cost of living, among other factors. The policy of the state health agency was to use these rates, with a maximum established by each state agency, as the official rate of payment. In other words, the prevailing rate in the community for either private duty or hourly nursing was paid to nurses for the care of patients under the EMIC program. Maximum rates of payment for nursing service were adjusted by state health agencies whenever nursing organizations adjusted their rates on the basis of a continuous study of local economic conditions. This policy was carried out easily in practice with apparent complete acceptance everywhere by graduate nurses.

Contracts for bedside nursing care to be purchased from voluntary agencies presented a more complicated problem. This was because the cost of visits as determined by these agencies in various parts of the United States varied so tremendously. This problem is about to be solved, however. The method of cost accounting recently developed by the National Organization for Public Health Nursing should assure every purchaser of nursing service a fair return from any agency with which a contract for service is made.

The EMIC policy of purchasing only bedside nursing care was based on the premise that other public health nursing functions would be provided by the health department nursing staff. Unfortunately, some local health departments could not meet the demands for public health nursing service from so many mothers for themselves and for their infants. Teaching of patients and families should be part of any complete program of medical care. If a nursing staff for this purpose is not available when a program of medical care is being planned, this service should be considered an important phase in potential expansion and should be added as soon as money and qualified personnel become available.

Bedside nursing care is expensive. After a period of trial the Children's Bureau was advised by the state agencies that a blanket authorization for continuous bedside care for a period of two weeks proved that this amount was considerably above the average amount required. When the original 2 weeks was reduced to 6 days this period proved to be long enough, in most instances. Authorization for extended care could be obtained easily in case of need. If communications happened to be delayed, a retroactive authorization was obtained.

Although a comparatively small group of mothers and infants received bedside care under special authorizations, nursing service as a whole was estimated to have been a large item, perhaps 20 to 30 percent of the cost of hospital care. The policy of providing bedside nursing service as indicated by medical need, unlimited by the cost of other services to the same patient in a comprehensive program, was proved to be sound. Critically ill patients in the home or hospital could have as much skilled nursing care as necessary. Our experience showed that this provision was used in relatively few instances but the records reveal story after story of the recovery of patients or of the relief of family anxiety that this special care brought about. The average cost of bedside nursing care to a mother in 1946, paid for from EMIC funds, was $16.35, and to an infant, $74.67.

WITHIN THE LOCAL FRAMEWORK

Early in this paper I referred to Dr. Sinai's study of the EMIC program. I should like to quote from his report again, in conclusion. Dr. Sinai says that "EMIC serves as a striking demonstration of joint effort and administrative resiliency. It would be hard to find another wartime program that grew to such comparatively huge proportions and still remained within the framework of an existing national, state, and local peacetime administration."

We of the Children's Bureau like to stress one inference in this judgment, the value of

keeping the program within the framework of state and local administration. We consider *that* the paramount lesson to be learned in retrospect from the operating of EMIC. We are more than ever sure of the best way to get for every mother and child, whoever or wherever they may be, the same kind and the same high quality of service. The way is to define together the goal of kind and quality and then help local agencies reach the goal in their own ways, according to their local practices and conditions.

Wives of servicemen, interested primarily in being with their husbands, were a mobile group moving from camp to camp and then to embarkation points. Generally, complete plans for their individual care could not be carried out within the scope of a single community program. The Children's Bureau had to plan so that wives could get essential maternity care wherever they might travel. New schemes had to be worked out to assure the provision of adequate medical care throughout the maternity cycle and hospital care at the time of delivery. At the same time that this new program was being established, nurses—federal, state, and local—were being mobilized to meet military requirements and to maintain essential nursing services at home for civilians.

To be able to help in preserving local patterns while assuring quality in service, we need more opportunities to learn about other's experience and experiments in EMIC and other programs, during the war or now. We need this information in order to fit the pieces of this huge nationwide puzzle together so that the medical needs of people everywhere in the United States may be effectively met. The way services are organized and administered will vary, and should vary. But the services made available to the people should, in the words of Dr. Franz Goldman, "be the best that medicine, dentistry, nursing, and the related professions have to offer in the prevention as well as the treatment of illness."

Presented at a joint meeting of the Public Health Nursing Section and the Subcommittee on Medical Care, at the annual meeting of the American Public Health Association, Boston, November 10, 1948.

Mental Health in WHO

(Continued from page 252)

tively concerned with the official adoption of the WHO mental health program, and the appropriation of sufficient funds for its support.

The program follows closely recommendations which the Federation put forward at the London Congress and includes collection and dissemination of information, field surveys, and team demonstrations of methods of survey, prevention and treatment of mental disorders. The first field surveys would investigate mental problems in rural communities, in industrial units, and among students. The Board pointed out that little is known about mental health in rural areas, most of the work so far having concerned urban groups. Also more needs to be known about the incidence of mental morbidity in industrial groups and psychoneurosis as a cause of absenteeism. Students are looked upon as in a plastic phase in which incipient mental health problems may often be dissipated by skilled help and their incidence reduced by preventive measures. Six traveling seminar teams would be provided to demonstrate technics of survey, prevention, and treatment of mental health.

The budget recommended to WHO is $942,550 ($217,180 from the regular budget and $725,370 from the supplemental budget.)

Every country stands to gain from the establishment of good national mental health programs even in remote countries. Whatever can be done to lessen the fears and tensions of mankind will tend to increase individual health and happiness and to heighten our hopes for a peaceful world. It is a gigantic task but we must begin somewhere and begin with a program of sufficient stamina to ensure substantial accomplishment. On this can be built an ever more effective program.

LEARNING TO LIVE WITH OUR CHILDREN

HENRIETTA FLECK

THERE IS SCARCELY a parent today who feels that he has learned all he needs to know, or even wants to know, about living with children. In this fast-moving world of ours, the order appears to be reversed, and parents have to learn in an accelerated tempo to keep pace with their offspring. Baffling problems continually confront parents, problems which demand additional information, skill, or insight.

Today, bewilderment is almost universal. Children are confused by the turmoil around them. But parents, teachers, nurses, social service workers, and all others who are in touch with the world's disturbances share the anxiety and likewise the sense of need for a search of all available resources to cope with existing conditions.

It is one of the ironies of our advanced civilization that we require comprehensive and thorough training for every important profession and career that serves human life and well being, and disregard certified preparation for parenthood. In most instances a diploma or license, certifying to the specialist's skill, are required. But parenthood, in some respects the most vital of all, because of its identity with civilization and human progress in general, has remained one of the neglected areas, requiring no efficiency certification, no credential. Almost anyone can become a father or a mother wth complete legal and social sanction. The amazing fact is that families turn out as well as they do.

Dr. Fleck is chairman of the Home Economics Department, New York University.

Some attempt to define and to clarify important aspects of parent education seems imperative before resources can be explored or intelligently selected. To be functional, parent education must be vital and needs to deal with the specific problems of everyday living. Consideration must therefore be given to the adjustments necessary in our changing society. Parents must be educated to face the ascending and descending problems of war and peace, prosperity and poverty, health and sickness, intelligence and ignorance, and a host of others. The standards and thinking of an ox cart era cannot be applied consistently to the atomic age.

More intimate than the solution of personal problems is the importance of continuous examination and clarification of values, attitudes, and beliefs about parenthood. What kind of relationships should exist between parent and child? Should one of them dominate? How should problems be solved and decisions be made? What should be the role of the child in the family? How may parents develop a unified philosophy of living and thus present a united front? A parent will govern his actions largely by what he believes and by what he considers important.

More than ever, it would seem that parents need the sustaining and balancing force of a philosophy of life. If democratic living is to be emulated and preserved it will need to be accomplished largely by an enlightened parenthood that is strong enough to surmount barriers and press with determination toward attainable goals. In democracies a high value is placed on the worth of the individuals.

Here every member of the family should have the privilege of living in a home where he can develop to the utmost of his capacity. By optimal development and continuous growth, parent and child will have richer, fuller and happier lives and make greater contributions to their immediate and their wider worlds.

No less important is the democratic concept of sharing both privilege and responsibility in the home and in society. To the limit of his capacity the child should share the family responsibilities. The purpose is not merely to lighten the burdens of other members of the family, but to help him comprehend his place among other persons and to teach him the grace and cooperation necessary for working with others inside and outside of the home. There is the greater possibility also of satisfying such basic needs as a feeling of security and of recognition. The ability to plan more effectively should emerge with the opportunity for participation.

A third ideal, inherent in democracy, is the intelligent acceptance and the satisfactory solution of important problems. Child and adult alike should be able to reach that level of maturity at which they do not have to be told what to do, that level of development at which they are able to make sensible decisions based on an estimate of available data, a consideration of logical consequences, and the will to proceed. Parents can develop such qualities in the child by example and by wise direction. In doing so, parents are prone to give more attention to their own decisions if they are aware of the scrutiny of the child on their conduct. Many a parent has lived to face the frown of his child when the parent's decision and conduct were not consistent with admonitions urged upon the child.

Not only is the evolution of a democratic philosophy important in parent education, but it must be realized that parent education cannot succeed unless it can generate its own momentum. To be truly effective, parent education should become self-education and be sought especially from a sense of real personal need. Richer returns are possible if parents pursue education in order to find answers to their own problems and if they are permitted to have a vital share in planning of program.

Accordingly, an exploration of all the available resources for parent education becomes important and it is this era that we are chiefly concerned with in this discussion.

MANY RESOURCES are at hand whose potentialities as media for parent education have not been utilized adequately. Teaching materials, the tried and progressive methods, interested agencies, and qualified leaders will need to be recruited in order to achieve the possible goals in this category.

From the standpoint of range of subject matter, depth of interest, and teaching potential, one of the most vital resources in parent education is the use of films. The effect of seeing the problems and relationships of a family portrayed on the screen is something more than a momentary dramatic thrill. To see the action sequences visualized before their eyes, often produces lasting benefits. Such films as "Human Growth,"[1] "Shy Guy,"[2] "A Child Goes Forth,"[1] the "Human Relations series,"[1] and "So They Live,"[1] afford such opportunities. Any of these films might be used in classes, at club meetings, for community gatherings, at school functions, or on other occasions where parents or young people gather.

Many of the current movies constitute collectively a resource whose values in this connection are seldom comprehended. True, the worthy must be screened from the total. There is a fair degree of certainty that a year's production will yield a good average of films which are concerned with home situations. Analyzing the role of a parent, child-parent relationships, or family problems in a film can do much to generate insight and critical evaluation of the requisites of desirable family relationships.

Filmstrips may not hold the emotional appeal contained in films, but they are much less expensive and easier to project. Principles of child development, points to consider in dealing with a family problem, sketches of various types of families, or aspects of management, may be stressed by this technic.

[1] New York University Film Library.
[2] Coronet Film.

Viewing a filmstrip affords an excellent opportunity to discuss common problems of parents. Among the filmstrips which are particularly effective are, "Is Your Family Fun,"[3] "Do You Know Adolescents,"[3] "Buy Words,"[4] and "Home Ground".[5]

When the filmstrips are accompanied by recordings, as in the first two filmstrips mentioned, the effect is heightened. Expensive sound equipment is not required, for these recordings can generally be played on a phonograph. Sound-slide films have a potential value that bears consideration.

NEWSPAPERS are so numerous and so well known that they are often overlooked as a valuable resource. The news items which describe actual life episodes are full of human interest material, whether one agrees with the outcomes or not. The long and short features and magazine sections offer helpful subject matter for evaluating family and personal life situations. Parents should be encouraged to read newspapers for self improvement and for help in surmounting the baffling problems which children bring them. The advice offered by columnists on child development and parent education may not be compatible with a parent's ideas, but at least they challenge the thought processes and stimulate a discerning attitude.

Many current magazines are full of authentic articles by reliable specialists. Articles, currently numerous, depicting the life of a particular family, the steps in the physical development of an infant or growing child, or a review of current issues of interest to the family, such as medical care, the education of children, and the role of religion in the family, stimulate an examination of ideas. Many magazines have illustrations which portray such devices as treating the temper tantrums of children, methods for handling a jealous child, and suggestions for parent and child to become more companionable. The timeliness of the material and the popular language employed open this resource to a wide circle of interested parents. Again, controversial points may be examined and articles may be used as a point of departure for the discussion in parent education groups. There are a number of magazines which are devoted entirely to the needs of parents.

Collectively, with exaggerated aspects, cartoons present a cross section of human situations and current problems. Cartoons found in newspapers and magazines are prone to portray various angles of present-day parenthood in a succinct and humorous fashion. Parent education workers may find a collection of cartoons a valuable aid in teaching for improved parenthood. A single cartoon may be projected by an opaque projector if attention is to be focused on one point. Asking parents to bring cartoons about a topic to be discussed is a means of broadening the area and introducing related concerns.

Posters are an effective means of attracting attention to an important point in parent education. Pictures, cartoons, sketches, and other pictorial presentations may form the basis for a poster. To be most challenging each should emphasize a single point or theme. Posters should be placed where parents will have an opportunity to examine them. Clinics, hospitals, churches, social welfare agencies, department stores, and club rooms are suggested. Interested parent groups may be encouraged to prepare posters to bring their learnings to parents who have not shared their opportunities. The subjects to be considered for these posters are almost unlimited. Some suggestions are family nutrition, budgeting, safety in the home, use of leisure time, parent-child relationships, health, and others.

An exhibit placed in the corridor of a nursery or elementary school where parents pass frequently, in a store window, or in a club room, is an excellent means for bringing a wealth of information to parents. A practical wardrobe for a preschool child, an adequate diet for a growing child, hobbies which parents and children may share, or a collection of recommended reading for parents, may be helpful. Again, the aid of parents may be solicited in planning and arranging exhibits.

Bulletin boards in suitable places can serve

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[3] Methodist Publishing Company
[4] Household Finance Corporation.
[5] McGraw Hill Co.

as a challenge to parents. Newspaper clippings, pictures, and special arrangements can do much to sharpen an important aspect of parenthood. Some interesting subjects for a bulletin board may be the selection of toys for children, points to consider in selecting a summer camp, how children may share home responsibilities, and ways of reducing living costs.

THE RADIO is a resource that is available to most parents. Many programs on the air are especially designed for parents. Such programs as "Here's to the Family," "Juvenile Jury," and "Child's World," may open pertinent questions for a discussion of common problems. Many of the dramatizations on the radio deal with family problems and can be utilized in much the same way as current movies.

A study of advertisements for emphasis upon various aspects of family life can prove an enlightening and profitable experience. Many parents do not realize how much their attitudes and values may be influenced by the advertisements which they read in newspapers and magazines, or hear on the radio. A critical evaluation of the points emphasized may prove valuable.

Many pamphlets and similar literature which are free or inexpensive are available from government agencies and associations interested in parent education. Two pamphlets, released by the Federal Security Agency, Children's Bureau, are literally classical gems to parents. They are "Your Child From 1 to 6," and "Your Child from 6 to 12." The state departments of education and public welfare often circulate excellent leaflets on prenatal and child care. The extension services of state universities frequently issue bulletins on many matters of interest to parents. Associations concerned with parent education, such as the National Council of Family Relations, the Association for Family Living, the Congress of Parents and Teachers, and some religious organizations, are dedicated to the preparation of materials for parents and for educators of parents.

In addition to an exploration of the resources mentioned here, teachers of parents will wish to consider suitable methods for disseminating information. Only methods which will be most profitable to the group should be selected. Suggestions are lectures, discussions, committee work, reports, panel discussions, interviews, demonstrations, and others. Personal contacts with parents are among the most effective means.

Employing the technics of psychodrama, sociodrama, and role practice provide interesting potentialities for methods in parent education. Parents describe certain conditions involving family relationships or conflicts and then enact them in a spontaneous fashion for other parents to estimate. Through these technics parents can be helped to see their responsibilities, their behavior, and their attitudes, as well as their mode of thinking. The number of situations which may thus be examined is as broad as life itself. Some examples of situations which may be explored are problems dealing with money management, with an adolescent daughter's interest in a boy of another faith, or the way in which the family meets a crisis, such as illness in the family, the loss of the father's job, and in-law difficulties. It is well for the situations to evolve from the group, so that concerns common to all can be explored.

The resources and methods referred to here do not by any means exhaust the list. Every community offers its own unique resources, but to be useful there must be also the will to search for them. The important point to emphasize is that the resources be located and utilized.

In its final analysis the purpose of parent education is to persuade parents to adapt themselves to the pattern of their needs in today's world and equip themselves to function satisfactorily in it. This, in turn, involves maximum development, creative self-expression, increased sensitivity, an understanding of responsibility, and the promotion of cooperative planning on the part of all family members. Educators, likewise, must be alert to their needs and provide the incentive and the essential resources for accomplishing these ends.

INCOME AND EXPENDITURES IN PUBLIC HEALTH NURSING AGENCIES, 1947

DOROTHY E. WIESNER and SYLVIA WEISSMAN

INCOME and expenditure figures for 1947, in the last Yearly Review, have been tabulated in detail this year because of keen interest in rising costs and possible new sources of income. Data on 6 sources of income and 7 items of expenditure were tabulated for the 210 nonofficial public health nursing agencies which submitted usable information. When the findings are compared with those in a similar study for 1939, (Table 1) similarities are immediately apparent. No striking new sources of income, and no startling new ways of reallocating expenditures have appeared.

Among 152 agencies for which we have comparable data for 1943 and 1947, actual total expenditures rose about 30 percent. The median annual expenditure per nurse, including salaries, in 1943 was $2,560; in 1947 it was $3,268, an increase of 28 percent. The pattern of spending was similar. The Consumers' Price Index of the U. S. Bureau of Labor Statistics increased 28.8 percent during the same period.

TABLE 1. INCOME AND EXPENDITURES IN NONOFFICIAL AGENCIES, 1939-1947

	1947 median percent	1939 median percent
Sources of income[1]		
Contributions	54.0	56.4
Earnings	28.0	24.8
Tax funds	7.5	6.3
Interest on capital funds[2]	0.7	1.5
Grants or payments from national or state nonofficial sources	0	——[3]
Other income	0.1	0.4
Items of expenditure[1]		
Salaries	78.1	78.2
Transportation	9.6	8.7
Rent and related expenditures	4.1	4.0
Office supplies	2.1	3.4
Nursing supplies	1.7	1.7
Retirement	0	——[3]
Other expenditures	2.4	0.9

[1] Percents do not add to 100.0 because medians are used.

[2] Includes transfer of capital funds also in 14 instances

[3] Not tabulated separately in 1939

SOURCES OF INCOME IN NONOFFICIAL AGENCIES

1. *Contributions.* Table 1 indicates that the median percent from contributions was 54. Exactly three fifths of the 210 agencies received from 40 to 69.9 percent of their funds from contributions. Only 3 reported no contributions, but 10 reported 80 percent and more of their funds from contributions, the highest being 97 percent. The community chest is the most usual source of contributions. Only 39 of the 210 reported no such participation, and only 10 of these were in chest areas. Of these 10, five were Red Cross nursing services which seldom receive funds from community chests.

Membership dues were reported by only 41 agencies. The total amounts secured varied from $5 to $18,500. The median amount was $450. A list of these 41 agencies is available to NOPHN member agencies on request.

The American Red Cross contributed to

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15 agencies, only 8 of which used the term "Red Cross Nursing Service" in their names. Community funds, other than from community chests, were mentioned by 14 agencies. The largest of these were the Greater New York Fund and the United Hospital Fund of New York, in New York City. Some county fund-raising groups also made appropriations.

Other contributions included money from thrift shops, individual gifts, annual drives, gifts from fraternal organizations, and from local foundations.

2. *Earnings.* An increase in percentage of earnings in 1947 over previous years was found. All of the 210 agencies reported earnings, the range in terms of percents of total funds received being from 3 to 64, with a median percent of 28. Only 9 agencies reported less than 10 percent of total income from earnings; and only 10 reported 50 percent or more. Only 4 of these 19 agencies employed 10 nurses or more.

Earnings from individual patients in the median agency made up about 16 percent of the total income, but individual variations for the 210 agencies ranged from 2 to 52 percent. Earnings through insurance companies in the median agency were about 10 percent. Only 7 agencies reported no earnings from insurance contracts. The range for the others was from less than 1 percent to 41 percent. Industrial concerns paid for service from 46 of these agencies. Although 85 nonofficial agencies provided student affiliations in 1947, only 39 reported income from fees for student affiliation or observation.

Other earnings reported by 76 agencies, small in amounts but showing some useful sharing of skill and facilities, were from nursing service for private schools and day-care centers, parents' classes, college nursing programs, teaching in schools of nursing, supervising small nearby agencies, and from tabulating data for nearby agencies.

3. *Tax funds.* Table 1 shows that 8 percent of the income of the median agency among the 210 agencies came from tax funds. The principle of separating tax funds from earnings has been questioned. One director argued that if the official agency paid on a per-visit basis the money was earnings, but if the money came as a lump sum it was more of a contribution. Recognizing this point of view, we nevertheless have studied tax funds as a separate source of income and hope to present further material about such money in a subsequent paper. In 1947 almost 80 percent of the agencies received tax funds, as compared with 71 percent in the 1939 sample.* Money from Emergency Maternal and Infant Care was reported by 37 agencies; Veterans Administration by 6; Old Age Assistance and other Social Security agencies by 35. These of course are new sources of tax funds since 1939. Only 6, mainly small New England agencies, reported 50 percent or more of their incomes from tax funds. Welfare agencies were reported as appropriating money to 86 agencies; health departments to 45; and boards of education to 25. County and local governments, department not specified, appropriated money to 58 agencies.

4. *Interest on capital funds and endowments.* Less money was reported from interest on capital funds than from tax funds,—$631,000 from interest on capital funds, and $665,000 from tax funds, for the 210 agencies. Only 11 of the 210 agencies received 20 percent or more of their incomes as interest, and 77 agencies received none. The highest percent was 76, in a small New England agency. Only one agency west of the Mississippi reported 5 percent or more of its funds from such a source. Fourteen agencies reported the use of capital funds or the transfer of reserve funds to be used for current expenses.

5. *Grants or payments from national or state nonofficial agencies.* In previous years, data were not secured separately about such money. Some agencies included these funds in contributions, and some in earnings. In 1947, of the 210 agencies 91 reported money from these sources, a total of $190,000. Tuberculosis associations were the most frequently reported as sources of income, by 41 agencies; cancer committees by 32; infantile paralysis chapters by 32. Parent teacher associations and planned parenthood leagues were

* Wiesner, Dorothy E. Tax funds in nonofficial agencies. PUBLIC HEALTH NURSING, v. 33, February 1941. p. 111-116.

also in this category. A list of agencies receiving such funds is available to NOPHN member agencies.

6. *Other income.* Such money included sale of supplies, rental of sickroom equipment, refunds, receipts from dental clinics, and loans. The sum of such income was $64,500. Only 29 agencies reported 2 percent or more as "other income."

Other comments about income data. Of the 210 agencies in this sample, 131 reported their financial data on a calendar year. Years ending in September or October were second. The choice of the fiscal year sometimes depends on the fiscal year of other community agencies. Because statistics of work done are usually asked on a calendar year basis, and because these need to be related to expenditures, many agencies find the calendar year for both more satisfactory.

Many agencies are eager to find new sources of income. Of the 210 in the study only 38 agencies received money from all 6 listed sources; 62 agencies received income from 5; 62 from 4 sources; 34 from 3 sources; 14 from 2. Many agencies might benefit from investigating some of these sources in their communities.

EXPENDITURES IN NONOFFICIAL AGENCIES

1. *Salaries.* Of the 210 agencies, 141 spent from 75 to 84.9 percent of their money for salaries. The median percent was 78.1. This proportion remains about the same each time we study expenditures in Yearly Review replies. In view of cost studies in public health nursing services in health departments, for which data about some items of expenditure are not easily obtained, this fact may be useful. The larger the agency, the higher the percent of money spent for salaries. In one-nurse agencies, the median for salaries was only 73 percent, and the percent rises regularly as the size of the agency increases. In agencies employing 25 nurses and more, the median for salary expenditures represented 82 percent of the expenditures. The lowest percent reported paid for salaries was 45 percent, and the highest, 90 percent.

2. *Transportation.* Transportation is second to salaries as an item of expense in public health nursing. We found that in a small sample of agencies the actual increase of expenditures for transportation from 1943 to 1947 was 30 percent. Table 1 indicates that the median percent of expenditures for transportation rose from 8.7 in 1939 to 9.6 in 1947. In the 210 agencies, $673,000 was spent for transportation as compared with $7,500,000 for salaries. Percents ranged from 1.7 to 42.4 percent. Larger agencies spent less in proportion to total expenditures than did small agencies. Among the 25 agencies employing 25 nurses or more, none spent as much as 10 percent, but 8 agencies employing less than 15 nurses spent 20 percent or more. We found an increase in number of agency-owned cars in nonofficial agencies. This may be the result of individual nurses' not being able to purchase cars. Both official and nonofficial agencies are disturbed by costs of transportation, yet realize that without adequate transportation, costs of home visits are higher.

3. *Rent and related expenditures.* One reason for the low percent of rent in many agencies is that rent is donated and entered on the yearly accounts at the rate of $10 per nurse per month. The median percent spent for rent was 4.1. The range was 1.0 percent in a California agency of 35 nurses, rent estimated, to 17.8 percent in a Massachusetts agency employing 1 nurse, rent actually spent. The median of 4.1 percent is a representative average figure, since 103 of the 210 agencies spent between 3.0 and 4.9 percent of their money for rent.

4. *Office supplies.* Such supplies include stationery, records, postage, telephone, typewriters, and other office equipment. The median percent spent for such items was 2.1, and 139 agencies spent from 1.0 to 2.9 percent of their money for such items. Nine agencies spent 5 percent or more, all of them small agencies. The highest percent so spent was 10.

5. *Nursing supplies.* Only 1.7 percent of expenditures was made by the median agency for such purchases as bags, materials used in them, dressings, and other nursing supplies. One large agency with an extensive orthopedic service spent 5.4 percent of its money for

such items, and 18 others spent 4 percent or more. Forty agencies spent less than 1 percent.

6. *Retirement.* Information on retirement was not asked for separately, but because so many agencies gave the actual amounts spent, the data were tabulated separately wherever possible. In 1947, many nonofficial agencies joined the National Health and Welfare Retirement Association, and 118 of the 210 participated in some retirement plan. Many community chests have encouraged such participation. Of the 71 who gave figures of the amount spent, the median percent was 3.6 of total expenditures. Employees, of course, also contributed. Twelve agencies spent 5 percent or more of their money for retirement, 7 of them in New England, 4 in the Middle Atlantic states, and one in Illinois. Agencies joining the National Health and Welfare Retirement Association before October 1, 1947 were entitled to past-service benefits for participating personnel employed on or before October 1, 1945, and made higher initial payments and subsequent payments for these employees. Those joining after October 1, 1947 paid only 5 percent of their payrolls for participating employees.

7. *Other expenditures.* Other expenditures included dues, books and subscriptions, conventions, public relations, and occasionally money for special equipment. The extra services of an agency, such as dental clinics, appear here. The median percent was 2.4. Ten agencies accounted for 10 percent or more of their expenditures under "other items," and 16 reported no such expenditures.

Other comments about expenditure data. We had comparable 1943 expenditure figures for 152 of these agencies, and were able to calculate the percentage of change from 1943 to 1947. Only 5 reported decreases, all because of smaller staffs in 1947. The median amount of increase was 34 percent. Six agencies more than doubled their expenditures, 4 of them California agencies. So far as size of agency is concerned, the small agencies showed greater percents of increase than the large ones. Forty-three agencies increased 50 percent or more, and 33 of these employed less than 10 nurses.

SOURCES OF INCOME IN COMBINATION AGENCIES

Of the 32 combination agencies returning Yearly Reviews, five were one-nurse agencies. The largest employed 57 nurses. Only seven others employed 25 nurses or more.

A combination agency is defined as an agency jointly administered by representatives of both official and nonofficial agencies, financed by tax funds, earnings, and contributions, in which all field service, with the occasional exception of school nursing, is rendered by a single staff of public health nurses. It is difficult to classify certain agencies from year to year as to their combined state.

Financial data from such agencies are complex. Occasionally, tax money does not appear as either actual income or expense, although salaries or rent or supplies were paid from it. Occasionally both the state and the local health departments appropriate money to the same agencies, sometimes for different purposes and on different bases. Simplifying the financial data to make comparisons possible took perseverance and tolerance on the part of the 24 agencies whose figures are usable for study. Table 2 shows the median percent of income from 6 major sources, and the median percent for 7 items of expenditure, compared with nonofficial agencies.

It is noteworthy that in combination agencies, 36 percent of income came from tax funds, as compared with only 8 percent of such income in nonofficial agencies. The low percent of earnings from individual patients in combination agencies,—9 percent, as compared to 16 percent in nonofficial agencies, is also of significance. Percents of earnings from individual patients among the 24 combination agencies ranged from 2 to 22 percent. Earnings from visits for insurance companies were only 5 percent, as compared with 10 percent in nonofficial agencies.

Only 4 combination agencies reported no income from community chests, these in small villages not listed as chest areas. Three combination agencies provided industrial nursing to plants, for which they were paid. Nine reported other earnings such as from

(Continued on page 281)

NURSE MIDWIFERY TODAY

A study made by the Nurse Midwifery Section of the National Organization for Public Health Nursing of practices in nurse midwifery and preparation for it

ALTHOUGH nurse midwifery has a long history in Europe and is well established, its acceptance in the United States has been slow. Nurse midwifery in this country is a comparatively recent development. Previous to 1933 American nurses desiring midwifery training secured this in schools abroad, primarily in Great Britain. In 1933 the Maternity Center Association established a school of nurse midwifery in New York. The Frontier Nursing Service opened its school in 1939, and Tuskegee Institute in Alabama administered another school from 1939 to 1945. The Catholic Maternity Institute founded a school in Santa Fe in 1945.

It is timely that those concerned with nurse midwifery analyze existing practices in nurse midwifery in order that recommendations can be made which will lead to more effective service to mothers and babies. With this in view the executive committee of the Nurse Midwifery Section appointed two subcommittees to study and evaluate standards for schools of nurse midwifery and to study and set standards for the practice of nurse midwifery.

This is a report of the survey undertaken by the two subcommittees, objectives of which were:

To determine how graduate nurse midwives are using their special preparation in midwifery

To learn in what localities nurse midwives are being employed

To learn which types of agencies employ nurse midwives

To study the educational preparation of nurse midwives.

Members of the two subcommittees cooperated in preparing a questionnaire and in studying the data reported. The Section had an enrollment of 115 members at the time the study was begun in April 1948. Of these 15 were not nurse midwives, as the Section is open to all NOPHN members interested in the broad field of maternity. Ten members were situated outside of continental United States. Questionnaires were sent to the remaining 90. This figure represents approximately 40 percent of all the nurse midwives graduated from American schools of nurse midwifery. Fifty-five questionnaires, or 61 percent of those sent, were returned and included in this study.

The questionnaire was set up in two parts. The first part comprised 10 items on practices in nurse midwifery; the second part 4 items on their preparation.

In this preliminary report only the items relating to the objectives stated at the begin-

Members of the subcommittee to study and set standards for practice of nurse midwifery are: Sara E. Fetter, Chairman, Laura Blackburn, Ruth Doran, Helen L. Fisk, Jane Harshbarger, Grace Martin, Ruth Olson, and Freda Parks.

Members of the subcommittee for study and evaluation of standards for schools of nurse midwifery are: Ernestine Wiedenbach, Chairman, Hattie Hemschemeyer, Ruth Lindberg, and Hedwig Cohen, secretary to the Section.

ning of the report will be discussed. The committees will report on other findings at a later time.

This study is based on data contributed by 55 nurse midwife members of the Section. Among the 55 are 5 who are graduates of foreign schools of nurse midwifery. The remaining 50 represent about one quarter of the number of the graduates of American schools of nurse midwifery. Since they are members of an NOPHN section it is readily seen that the findings are biased in favor of public health nursing activities although national membership is open to all interested nurses and nonnurses. More questionnaires were returned from one or two areas in the country than from others. Therefore, the data—especially as they concern geographical location—are not representative of the country as a whole.

FINDINGS OF THE STUDY

The titles of positions of those reporting are shown in Table I.

TABLE 1. POSITIONS OF 55 NURSE MIDWIVES

Director and assistant director of school of nurse midwifery	3
Chief, bureau of public health nursing services	1
Director, and assistant director, private maternal health agency	3
Director, private public health nursing agency	2
Regional nursing consultant	4
Maternity consultant, on state and city levels and in private agencies	9
Maternity consultant, and/or supervisor, school of nurse midwifery	2
Assistant professor of obstetric nursing and/or nursing education	4
Instructor and/or supervisor in maternity nursing and/or delivery service	6
Public health nurse midwife and nurse midwife	16
Director, student health service in university	1
Assistant chief nurse in surgery	1
Fellow in advanced obstetric nursing	1
Housewife	2

There were several points of interest. Twelve nurses are concerned with the programs of two schools of nurse midwifery, 11 of these in one school. Of the total number, 39 are in the field of public health; 11 in hospital programs; and 5 in miscellaneous fields or not in practice. Among 55 are 9 who are primarily administrators, some with teaching responsibilities; 14 are consultants on various levels; 8 are assistant professor or instructors in maternity nursing, obstetric nursing, or nursing education; 3 are supervisors; 16 are staff nurses, and 5 are in miscellaneous positions or not practicing.

Table 2 presents the geographical distribution of those participating.

TABLE 2. GEOGRAPHICAL DISTRIBUTION OF 55 NURSE MIDWIVES

New England	7
Middle Atlantic	17
East North Central	3
West North Central	0
South Atlantic	14
East South Central	1
West South Central	6
Mountain	4
Pacific	1
Alaska	2

It has been said before the geographic data are of limited significance. It has been assumed that most nurse midwives are employed in the southeastern part of the United States. The study shows a rather wide distribution among 19 states, District of Columbia, and Alaska. Representation is missing in only the west north central area.

In Table 3 one sees the types of employing agencies in which the 55 nurse midwives function.

TABLE 3. AGENCIES IN WHICH 55 NURSE MIDWIVES FUNCTION

Schools of nurse midwifery	11
Federal agency	3
State or territorial health department	14
County health department	3
City health department	1
Private public health nursing agency	4
Veterans Administration hospital	1
University school of nursing	9
Hospital school of nursing	1
Private maternity association	3
University health service	1
Missionary board	1
Not employed	2
On special fellowship	1

A successful midwifery service is dependent upon close cooperation and good teamwork between the obstetrician and the nurse midwife, each performing those functions for which he or she is prepared. The province of the nurse midwife lies in the care of the normal mother. When abnormalities are suspected

or develop she assumes the usual nursing role in the nurse-doctor relationship.

The extent to which the nurse assumes the responsibility for labor and delivery in public health work is recorded in the following figures, and indicates that at present this is an important but numerically rather small proportion of her work. Of those reporting in the study 23 nurse midwives have responsibilities for the conduct of normal deliveries. Again, it must be pointed out that 12 of this number are connected with services which are a part of schools of nurse midwifery. That leaves 11 nurse midwives rendering direct delivery service and many of these report such service as a part of their teaching and supervisory program for untrained midwives.

Hospital experiences utilizing the work of the nurse midwife are as yet scarce in this country. Data collected in the survey which are yet to be analyzed indicates evidence of many situations in antepartal, labor, delivery and postpartal care, where the knowledge and skill of the nurse midwife in the future might be utilized.

A large percentage of the group under study report responsibilities in program planning, staff and community education, and staff supervision as shown in Tables 4 and 5.

TABLE 4. VARIOUS COMBINATIONS OF TEACHING RESPONSIBILITIES

Basic students only	2
Basic students and graduates	4
Basic students and staff nurses	5
Basic students, graduates, and staff	24
Graduate students only	1
Graduate and staff nurses	6
Staff nurses only	6
None	7

TABLE 5. RESPONSIBILITY FOR SUPERVISION OF STAFF NURSES

Types of supervision	
Home supervision	10
Clinic supervision	15
Hospital supervision	6
No supervisory responsibility	24

In addition to the above supervisory functions, 11 of the nurse midwives are responsible for the teaching and supervison of untrained midwives and 8 others are participating in educational programs for untrained midwives who are supervised by other members of the staff.

TABLE 6. RESPONSIBILITY FOR GROUP LAY EDUCATION

Mothers classes	5
Mothers classes and other lay groups	13
Lay groups other than mothers classes	18
No group education activities	19

The nurse midwives among both the hospital and the public health groups report active participation in program planning. Of the total number, only 10 report no such responsibilities and among these 10 are those in miscellaneous positions and not in practice.

Only one person reports working under no medical or nursing direction, although it is possible for her to call upon an obstetrician 100 miles away. Several nursing directors listed a medical director as the person they consulted for nursing guidance. Doubtless this means consultation of an administrative nature.

Many of the nurse midwives designated several persons to whom they looked for both medical and nursing direction. In such instances an arbitrary choice was made of one source for medical direction and one for nursing direction. The sources which were considered most helpful were selected (Tables 7 and 8)

TABLE 7. SOURCES OF MEDICAL DIRECTION REPORTED BY 55 NURSE MIDWIVES

MCH director	14
County health officer	7
Obstetric consultant	15
Chief of staff	9
Medical Board	1
Local obstetrician	6
No medical direction	1
Not in practice	2

TABLE 8. SOURCES OF NURSING DIRECTION REPORTED BY 55 NURSE MIDWIVES

MCH director	8
State director of public health nursing	4
Childrens Bureau consultant	4
Nurse midwifery consultant	9
Director of supervisor obstetric nursing	14
Generalized supervisor	7
Dean, school of nursing	3
Director of nursing education	3
No supervision	1
Not in practice	2

Table 9 presents data concerning collegiate education of the 55 nurse midwives. The data indicate a large percentage of those with

advanced preparation in addition to special study in midwifery.

TABLE 9. COLLEGIATE EDUCATION OF 55 NURSE MIDWIVES

Two or more degrees in general education, public health nursing, and nursing education	14
One degree in general education or nursing education and in addition completion of the program of study in public health nursing	7
One degree in either nursing education or public health nursing	20
No degree. Completion of program of study in public health nursing	6
No degree. Courses in nursing education or in public health nursing	4
No data	4

TABLE 10. GRADUATES OF SCHOOLS OF NURSE MIDWIFERY

Catholic Maternity Institute	1
Frontier Nursing Service	5
Maternity Center Association	41
Tuskegee	3
Foreign schools	5

SUMMARY

It was found that the group of 55 nurse midwives, representing 25 percent of the graduates from the four American schools of nurse midwifery (3 in existence today) have a level of preparation as nurses and midwives comparable to well prepared nurses in other specialties. It was found that the group are spread throughout the country and are employed in all types of agencies and programs in which nurses have demonstrated their contributions to the health of the nation. Only one of the nurse midwives is on her own in an isolated missionary community. All the others have medical and nursing guidance available. Twenty-two of the total number have some direct delivery function, and in addition the majority carry heavy teaching responsibilities for student and staff nurses within the hospital and the public health field, and for the untrained midwife and the general public.

Income and Expenditures

(Continued from page 277)

supervision of a nearby VNA, relief work for another agency, supervision of a nursing home, and work in play schools and other private schools.

Of particular interest is the reporting of payment for student work by 12 of these 24 agencies. Only 5 combination agencies provided affiliation service for which they were not paid.

EXPENDITURES IN COMBINATION AGENCIES

Table 2 shows the similarity in the percents of expenditures for certain items in the two kinds of agencies. The median expenditure per nurse in 1947 in combination agencies was $3,484, as compared with $3,268 for nonofficial agencies. The increase in expenditure per nurse from 1943 to 1947 in the median combination agency was 34 percent; the comparable figure for nonofficial agencies was also 34 percent.

TABLE 2. INCOME AND EXPENDITURES IN 24 COMBINATION AGENCIES AND 210 NONOFFICIAL AGENCIES

	Combination agencies 1947 median percent	Nonofficial agencies 1947 median percent
Sources of income[1]		
Contributions	43.6	54.0
Tax funds	35.6	7.5
Earnings	15.4	28.0
Individual patients	(8.9)	(15.5)
Insurance visits	(5.2)	(9.6)
Grants or payments from national or state nonofficial sources	0.9	0
Interest on capital funds	0.5	0.7
Other income	0.6	0.1
Items of expenditure[1]		
Salaries	78.5	78.1
Transportation	9.3	9.6
Rent	3.6	4.1
Office supplies	2.4	2.1
Nursing supplies	1.1	1.7
Retirement	0	0
Other	2.8	2.4

[1] Totals do not add to 100.0 because medians are used.

THE INTERVIEW IN SCHOOL NURSING

MARIE SWANSON, R.N.

PART 2

IN PART 1, certain basic principles of interviewing were outlined together with pointers on the necessary preliminaries. We now come to some of the different types of interviews which are part of the nurse's work.

INTERVIEWING TO GET INFORMATION

Whenever possible, facts are obtained from records rather than through interviews. They are more reliable. The nurse's time is saved and she is showing a respect for the time and patience of the other person. However, a request for information may serve as the stated reason for an interview designed for another purpose but one which if introduced too abruptly, might arouse too much emotion or antagonism. Specific questions are delayed until as much of the information as possible has been obtained through spontaneous conversation. When direct questions must be asked, they are put in nontechnical simple language and asked without hesitancy or apology and with no suggestion of embarrassment.

Questioning the accuracy of any statement or requesting substantiating evidence is delayed until a final summary. It is then presented in a non-critical and matter-of-fact manner. The nurse recognizes that inaccuracies may be due to unwillingness, prejudice, ignorance, inarticulateness, and perhaps most frequently to a misunderstanding of what is desired. Inevitably some distortions appear, from a desire to please or from self interest. Many inconsistencies are irrelevant and may be ignored.

INTERVIEWING TO GIVE INFORMATION

This may seem to be the "easiest" type of interview, but in one way it is more difficult than the process of obtaining information. In the latter case, it is easy to know that one has or has not obtained it. In giving information, skill is needed to determine whether or not the person has understood and accepted the information.

The nurse's words often mean something very different to the parent or child from what they mean to the nurse. Sometimes his hearing is faulty and he covers up his lack of understanding. Until he gives back some evidence that the ideas did get across to him, one cannot regard the interview as completed. Having him repeat verbatim words said gives no assurance of understanding. A more subtle method of checking is necessary.

A person who wants information, receives it more readily, keeps it longer, and is more apt to use it than one who feels no need for it and receives it passively. Before giving a person, whether parent or pupil, information the nurse feels he should have, she considers the matter from his point of view and how he might use it. An endeavor to lead him to feel the need and request the information, instead of giving it to him gratuitously, is worth the extra effort involved.

A nurse may be asked to give information she does not have. Perhaps it is information she should be able to supply. She arranges to secure and send it in the most convenient way to the person desiring it. Perhaps it is information for which the nurse is not responsible but what she could secure. Before deciding to do so she should answer these questions. Should the person have this information? If so, will it be more valuable for him to get it for himself? Can the nurse afford the time to secure it for him?

When it relates to a subject to which the nurse has given no previous consideration, she may say so and that she will see what she can find out. She need not be apologetic. There may be occasions when the opportunity to say "I do not know" may be an asset in demonstrating one's frankness and sincerity.

INTERVIEWING TO SECURE A CHANGE OF ATTITUDE

Such interviews require the most careful approach, the most cautious handling. They are the most difficult on which to evaluate progress. To this problem—change of attitude, the nurse may apply the procedures she has seen used in medical practice. She seeks a diagnosis before she plans treatment. She studies the situation through listening to the person talk on this and related topics, in order to learn *what* his attitude is and as far as possible to learn *why* it exists. If she can help to recognize his own attitude and analyze the reason for it, she may have helped him take an effective first step toward changing it. Although attitudes are "standardized reactions in giving types of situations and experiences," they are usually based on a definite personal experience.

Some attitudes are hard to change because they are based on a deep emotional involvement. Others in which less feeling will be aroused are more easily modified. Unless the nurse begins at the point where the individual is in his thinking, her chance of bringing him to the desired point of view is lessened. When she knows what the experience was which determined his attitude toward the present situation, she has an opportunity to supply data which may help to counteract the previous experience.

Since an attitude toward a situation is determined less by its intrinsic merit than by its relation to the individual's personal interests as he sees them, the nurse may wish to help him see more clearly the direction in which his personal interests lie. What parent's life will not be made more comfortable if his child is ill less often? The nurse may either help him promote his own interests as he sees them, or when indicated she may precede this by helping him see his own interests differently. Her information and experience in health matters often enable her to point out factors and possible outcomes which have not previously occurred to him and which will show him new potential effects on his personal interests.

When surgery is indicated and parents hesitate, three frequent reasons are,—fear of operations, the considerable expense, doubt that such drastic action is necessary. The direct questions, "Are you afraid, do you hate to spend the money, or do you think it isn't necessary?" might fail to bring out the true reason. Words are used to conceal as many attitudes as they disclose. An informal discussion of tentative plans for arrangements, such as "If you should decide later to do it, where would you be most apt to go for it?" might give more clues as to the real attitude than a direct question. Almost any topic which will keep him talking in the desired area is worth trying. Telling about other cases, with some points of similarity or dissimilarity known to the parents, may serve the purpose. If fear is found back of an attitude, the person may be shown that possible results of no action are really more fearful than those of action. If the reason is financial, it may be shown that no action is apt to prove eventually more expensive than desired action.

Need for security is one of the strongest emotions in determining attitudes. The nurse can utilize it appropriately for urging practically all health habit improvements and treatment of many types of defects.

While ordinarily attitudes change slowly, in time of emergency and emotional stress,

the individual is more vulnerable to change. This is one reason why in school nursing work one never marks a case closed nor despairs of ultimate success, no matter how discouraging a situation. Keeping in touch with the child, the family, or the teacher, the nurse is ready to step in when some element in the situation changes. It may be a misfortune or a good fortune; no job or a better job; removal to a new neighborhood; and addition to or a subtraction from the family group; a school promotion or a failure.

When a nurse makes a suggestion to a parent for a change in his child's behavior, it may be done in such a way that the parent feels criticized by the very necessity for the suggestion. Or it may be done in such a way that he not only retains his self-respect but even feels complimented that the nurse seeks his help. Sympathetic understanding of another's problem contributes to establishment of a good partnership relationship; pity has a sting which causes the individual toward whom it is directed to lose stature with himself. Whether dealing with pupils, parents, or teachers, the nurse's contacts should build up the person, to himself, not tear him down. The nurse may get a clue for a means of changing an undesirable habit if she discovers how or why it was set up in the first place. This is apt to be particularly valuable in nail-biting when often the cause has vanished long since and the biting is continuing only because attention has not been drawn to it. The nail-biter's and not the nurse's understanding of the original cause is the vital point and may be all that is needed.

The nurse may have arranged an interview with a parent in order to find a key to a child's problem, to obtain data about him, or to help the parent make plans for him. She may find however that before she can take up the child's problem she must help the parent, as a troubled human being. Even allowing him to blow off steam, to tell his troubles to her, may be a valuable contribution to his welfare and happiness. When this is insufficient, referral to his family physician, spiritual adviser, or to an official of an appropiate cooperating agency may be indicated.

The nurse wants the parent to feel she considers him an equal with whom she can exchange information, ideas, and opinions. She asks a question or introduces a topic which will bring up something in which he can have pride. When he does talk, she listens for a point which can be related to the purpose of the interview.

When the conversation does get down to the child, some parents ask advice of the nurse before she is ready to give it. Authoritarian advice is avoided, as people seldom take it. What is desired is to help the person develop a healthy attitude of responsibility and of self-confidence in his ability to handle the situation himself. She may avoid answering his request for advice by asking him questions along the same line which will help him view all sides of the problem. She may supplement his information, or help him think through what outcomes can be expected from various possible modes of procedure. The nurse learns to accept parents' attitudes of anxiety or resentment toward her with the same objectivity with which she accepts those of dependency or gratitude.

When a parent cries during an interview it is usually better to go on with the discussion with a sympathetic but matter-of-fact attitude as if such behavior is not especially surprising. This helps the parent accept his own feelings and regain self-control.

Even in those rare instances when force of the law must be evoked (as in communicable disease control or attendance matters) the nurse makes it clear that she and the school staff are all subject to the law, which was set up neither by her nor by the board of education. The nurse helps parents to feel that she and other school personnel are employed by them and their neighbors to protect their children and all children, and that the laws in question were passed by the people of their state for the same purpose.

Specific questions concerning amount of income, rent paid, and similar matters, are seldom warranted in a school interview since the school does not engage in relief activities, but refers indicated cases to relief organizations. The nurse may tell the parent something of

the eligibility required in order to guide him when making his decision in regard to applying for help.

There are many occasions when the services of the nurse, if dealing with persons of superior intelligence, may be limited to helping secure a recognition of the problem. She may perhaps also give some assistance in outlining the sort of plan that might be made to meet it. The individual may know so much more about resources and possible procedures than does the nurse that it is unnecessary for her to continue in the picture while he makes his decision and completes his plan.

Interviewing Pupils

Children have a greater tendency than teachers, parents, or other adults to color their statements in accordance with what they think the nurse would like them to say. They are also apt to be more sensitive to her attitude toward them and if they distrust her or feel she distrusts them, they are more likely to withhold information. Evasion, hesitation, and misrepresentation convey a great deal to a nurse who has an intent and ability to understand what is signified. Assistance to the child in understanding his own mind may result in his straightening out some of the conflicts causing the confusion, and may prove more valuable than the original purpose of the interview.

Scheduling pupil interviews. An uninterrupted time and absolute privacy for interviews with pupils when certain problems are involved are as essential as in interviews with parents.

When the interview has been sought by the pupil or when it is one of a continuing series with a good relationship already existing, no delay in getting to the point is indicated. But if pressure has been used to secure the interview—"Go see the nurse"—or if improper behavior of the pupil is the reason for it, it is well worth the time and effort required to give him some evidences of personal interest, respect, and courtesy. Regardless of the occasion for the interview, the child must be made welcome as a person. Whatever the nurse's attitude may be (or must be in some instances) toward his behavior, she makes him feel her consideration for him as an individual apart from what may be undesirable behavior. When necessary she delays examination of matters charged with emotional conflict until some rapport has been established. When the amount of nursing service in the school is liberal enough so she and the child are already known to each other through working together on vision testing, getting ready for the doctor's examination, and conferences after absences, the necessary rapport is usually already established. He knows her as someone who has an honest concern with him and his problems and who will give him help. On this basis an intimate and confidential relationship can be built up quickly.

Unfortunately it is possible that the manner in which routine interviews with pupils are handled by the nurse may set up a barrier between them instead of laying a foundation for rapport. Situations in which the nurse must deal abruptly and hurriedly with individuals in the presence of other children, with part of her attention given to keeping order in the on-pressing group, should be eliminated.

To avoid such incidents, schedules may be established so that not all teachers send pupils to the health room at the same moment. Pupils can be taught to line up single file (with the line extending as far into the corridor as necessary) and to stop at an indicated distance from the nurse, so she and the pupil she is interviewing may have a degree of privacy.

At intervals it is valuable for the nurse to take stock of the routine interviews she is having and consider if some of them could be eliminated through setting up other procedures. Having a nurse see a child unless she takes time to give him some individual consideration may be a waste of his time, his teacher's, and the nurse's time with no purpose served. A nurse needs to spend enough time with a child to allow her nursing judgment a chance to function. Otherwise any other more convenient individual might better "pass" on him. An unpleasant experience when the nurse may seem to be indifferent to the pupil hampers the development of good relationship later.

Funny situations and little jokes are enjoyed by most children. However, referral to the nurse is apt to seem to a child a much more serious occasion than it is from the nurse's point of view. Therefore flippant and facetious comments, so many of which are above the child's level are poor practice. Children do make serious statements which are almost irresistibly funny to adults. While the nurse may control properly her own reaction, other adults or older children present may be less considerate. In such cases the nurse courteously explains to the child so he can laugh too.

Having a certain, though perhaps quite limited time periodically when pupils have an easy informal access to the nurse, contributes to the development of a real rapport. Serious, though brief, consideration of a pupil's minor problems paves the way for opportunities to help him when more important situations arise. With a few exceptions, each interview which a nurse has with a child is an opportunity to do mental hygiene teaching through guiding him toward establishment of desirable emotional attitudes toward things which happen to him and toward people with whom he associates. She helps him understand his relationships with his teachers and with other children, and his ever-changing relationship with his parents. She helps him develop a good attitude toward the rights of others and a sense of responsibility for the welfare of others.

The highest type of nurse-pupil interview is the one in which the pupil voluntarily uses the nurse as a consultant in making a decision of his own.

Closing an Interview

Before concluding an interview the nurse may have the individual make a summary to be sure there is mutual understanding of what has been discussed. Then together they plan the next steps, focussing on immediate procedures though including distant goals as well. Each specifies what he is to do before the next contact and together they decide whether that contact will be by letter, telephone, through the pupil, or by another interview. In a pupil interview, the nurse may give the pupil a card with a note of the time when he is to return. It may happen that when an interview is "finished" because tension is relaxed, some of the most revealing items may then come out, which may have been considered too trivial or irrelevant to be mentioned earlier.

When there is difficulty in obtaining the objective of an interview, it may be wise to establish a good relationship and leave the way open for future contacts. An attempt to force on him advice or action he is not yet ready to accept may not only fail but may also make subsequent progress impossible.

Subsequent Interviews

In these, the introduction usually resolves around what has happened in the interim. The parent has an opportunity to ask questions about things not clear, recalled from the previous interview, or which have come up since. The nurse has an opportunity to use that principle of learning—repetition—in a graceful way to emphasize the most important features of any previous instruction. The parent who finds it hard to accept new ideas has had time to become accustomed to a "startling" proposal and may be ready to move forward a little further.

Recording an Interview

Not all interviews need to be recorded. Each should be counted, however, since a nurse needs to know where her time has gone. Only an instant is required to make a mark under the proper items on the daily report blank on her desk pad or in her travel notebook. In the case of a parent interview there is value in knowing there has been a contact even if no progress was made. At least a brief notation should be made—perhaps on the pupil's cumulative record—specifying date, which parent, problem considered, "no progress," and if possible the reason for no progress. Of course when progress was made there is no question of the value of recording the interview describing the progress made.

If no notes were made during the interview, it is essential to make them before beginning the next one. A good interviewer has a good memory. The nurse finds that with resolution

and practice she can greatly increase her ability to remember what she wishes to record. But her record can not be trusted as implicitly if made after the interview, and still less if another interview has intervened. Here again, no great amount of time is required, but a few notes should be made before proceeding to the next person, at least of progress made, difficulties encountered, new information obtained, and further steps necessary.

There is an unjustified prejudice against note-taking during an interview. Whether or not one make notes is determined entirely by circumstances. In an interview with a fellow worker, in which plans for future work are being made, each probably makes his own notes as the conference proceeds. When conferring with parents or pupils on a subject in which their emotions might be involved, a gesture toward note-taking might be upsetting. Even then, if one's attention doesn't seem to wander, if first attention is given to the person and only a minimum to the record that is being made, if the nurse looks the person directly in the eye most of the time, note-taking may contribute rather than detract from the success of the interview.

When the interview is for the avowed purpose of obtaining information, dignity and importance are added by the immediate and accurate recording of the material obtained. Confidence in the record is given to the individual if the nurse reads back or allows the person to read what she has written. Greater care may be taken to be accurate when there is this evidence that one's statements are to be recorded. When the nurse has been obliged to call on a parent to secure the parent's signature to the notice of a defect found, because it has not been signed and returned as requested, an increased emphasis is achieved if the nurse asks for a statement of his attitude toward the problem, enters it carefully, and asks him to read it and sign it. If he objects to signing such a statement, it is crossed out and his signature on the notice is accepted without it.

One can work out a simple code for recording, since no one else needs to be able to read it, which allows recording as rapidly as a conversation can be carried on. Loss of rapport comes when the interviewer stops the conversation to write tediously while the person being interviewed becomes bored or uneasy, awaiting the next question. Use of a well constructed form cuts down the amount of writing required. The form for obtaining history preceding a child's acceptance at a mental hygiene clinic is one illustration of this. Some nurses construct simple forms for a certain type of call, as eye defect, illness absence, animal bite, or others. An occasional run of carbon copies keeps her supplied.

When a person sees a record made of what he is telling there is increased need for assurance as to the interviewer's reliability and respect for all confidences given. Too little respect is sometimes shown. School staffs need a type of inservice staff education program to develop professional ethics similar to that carried on among physician and nurse staffs and similarly supplemented by disciplinary action when infractions occur.

It is a temptation to a nurse with skill in story telling to capitalize for their entertainment value some of the more striking incidents she encounters. This stimulates repetition of the stories by teachers, using them as conversational material, "Have you heard the latest about the ——— family?" Usually the nurse can find a less spectacular episode to illustrate a certain attitude of which the teacher should be informed.

When used to illustrate reports or to liven a speech, all identifying data must be modified and the story accompanied by a statement that this has been done, as otherwise enterprising minds will find a family on which to fasten it, and though it may be the wrong family, injury may result.

As mentioned above, in some instances no record of an interview needs to be made but in complicated situations the nurse may wish to write not only a full record of an interview for her own file, but may find it valuable to dictate selections from this, of which carbons may be made for others concerned with the family—other nurses, the attendance supervisor, the pupil's teacher, or the teacher of siblings. In some instances carbons are not indicated as information one of the workers should have might not be desirable to give

out to others. For the "average" case one record to go on the pupil's health record or into the family folder or the child's guidance folder, is all that is necessary.

INTERVIEWING BY TELEPHONE

It is preferable for the parent to call the nurse than vice versa, as the nurse is then assured that the parent has no objection to discussing affairs over the telephone. Those accustomed to a private line think of a telephone conversation as being personal and confidential. Those who use party lines especially in rural areas where identities of the subscribers are well known to one another, are apt to feel differently.

When the nurse must use the telephone in the school office, she must be sensitive to the lack of privacy and most discreet in her choice of problems to be discussed. Her statements must be guarded when there is any possibility of being overheard or if the parent fears they may be. Some parents feel it a violation of their privacy to have others know they were advised to have a physician. Some would not want a certain neighbor to hear discussion of a clinic appointment.

It is worth while for school administrator, school physician, nurse, and teacher to make definite, concentrated, planned efforts to encourage parents to develop the habit of calling the school to volunteer information when their children are ill at home or when plans are to be made for treatment of defects, or to obtain health information. It takes less time to be called than to call and it insures that the parent has no objection to a telephone conversation. Just as the parent coming to the school for a conference indicates an advance beyond the situation where the school must seek out the parent, so the parent's telephone call to the school indicates a desirable initiative on his part.

When the nurse does call a parent whose attitude toward such calls is still undetermined, she may open the conversation with a question that allows the parent to give little or much in reply. For instance, in the case of an illness absence, instead of asking, "Now just what is the matter with him?" one may say, "I hope he is not very sick" or "When do you think he will be coming back?" This gives the parent the privilege of just answering the question or as most of them are glad to do, of telling the nurse all about the child's condition and asking her advice.

In calling about treatment of defects, the question "Have you made any plans about treatment?" is preferable to "What plans have you made?" If the answer to the first question is "yes," usually the parent will go on with details. If not, the nurse can ask, "Will you please write me a note about it so we can have it for our files."

When deciding whether to make a telephone call instead of a home call, it is not enough for the nurse to put herself in the place of the parent and decide, "I wouldn't mind discussing that on the phone if it were my child." She must remember that her professional point of view on health matters is very different from that of many lay people and develop in herself a consciousness of possible sensitivities of others.

INTERVIEWING A FEEBLE MINDED PERSON

While a slow process, some information can be obtained or given, and especially attitudes can be influenced, if the I.Q. is not below 50. This is possible only when the nurse is patient, chooses simple words, carefully repeats over and over, allows as much time as is desired for each separate idea, and is sensitive to the person's reactions as expressed in any way, not relying just on his response in words.

As are some others, the feeble minded are extremely suggestible, so unusual care must be used when information is being sought, not to suggest answers by the form of the questions, facial expression, or tone of voice. Since they will naturally be reticent to give information until they feel confidence in the nurse and really accept some reason why she should be told these things, the nurse is unusually careful in her explanation. The full reason may be inexplicable to such an individual. As in other interviews, the judgment used in proper adaptation of scientific material to the level of the person interviewed, with his prejudices, interests and needs kept in mind, determines success or failure.

Using an Interpreter

When a parent has a language difficulty, the nurse must decide whether there is more to lose or to gain in using an interpreter. The calibre of interpreter available may be the determining factor. If it must be a child of the family who may be inept in conveying what is meant or who may even have purposes of his own in distorting the conversation, a postponement of the interview until a time when another adult who does speak English may be home, is one solution. Use of a teacher as an interpreter adds dignity to the interview and makes it easier to help the parent accept the nurse and the school as allies in securing the best obtainable for the pupil. The teacher also often has much of value to contribute directly. Also some foreign-born people have a greater respect for members of the teaching profession than for members of the nursing profession.

Interviews in the course of school nursing are usually for the purpose of obtaining information, giving information or to try to help a person change his attitude on a particular problem.

Improving One's Ability to Interview

At the conclusion of an interview with a pupil, ask oneself: Was the interview an active or a passive experience for the pupil? Was he left with the feeling he had settled his problem or at least knew what next step he should consider? In his feeling of responsibility for his own health increased or lessened?

Following an interview with a parent one may ask: Did I find out what the parents really thought about the problem? Did they feel I really knew what I was talking about? Was my information scientific and up to date, and interpreted so it was meaningful to the parents?

At the conclusion of an interview the nurse had sought, did the individual feel the time expended was worth while? Was the person who had sought the interview with the nurse satisfied that adequate consideration had been given to his problems as he saw them?

If one wishes to improve interviewing skill, it is well, after each interview to take a moment to review the original purpose and evaluate progress toward that end and any additional accomplishments. The nurse working in school situations can find opportunities to observe as a non-participant, skilled interviewers in action. She can be sensitive to successful (or unsuccessful) methods of interviewing which others use on her and to her own reaction to certain technics. She can read and re-read professional articles or reference books on interviewing in various fields, —counseling, social work, psychiatry, business, and research, as well as in nursing.

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FEDERAL HEALTH AND WELFARE LEGISLATION—81st CONGRESS

In the latter part of March several bills of particular interest to nurses were introduced in Congress.

Assistance for the Education of Professional Health Personnel

S 1453 (also HR 3894), introduced March 29 by Senator Pepper and others, provides grants and scholarships for education in the medical, dental, dental hygiene, public health nursing, and sanitary engineering professions, and for other purposes, in order to help meet the shortage of personnel and to help in constructing and equipping new schools and expanding existing ones. Only provisions relating to nursing are summarized here.

Payments to nursing schools providing basic or advanced training leading to a degree in nursing would be $200 per student on the basis of its average past enrollment and $1200 per student enrolled in excess of its average past enrollment. For a 3-year period beginning July 1, 1949, payments to schools of nursing providing training leading to a diploma in nursing, and providing tuition, board, et cetera, without charge to students, would equal $200 per student enrolled in the first year, $150 enrolled in the second, and $50 in third year. Payments to the schools can be used to meet costs of establishing, maintaining, and enlarging staffs and of maintaining and operating their facilities. At the end of three years, the size of future payments is to be determined on the basis of surveys and studies.

Any public or nonprofit school accredited by a body or bodies approved for the purpose by the surgeon general after consulting the Council (described later) would be eligible for aid.

Provision is further made for federal aid for construction and equipment.

The surgeon general of the Public Health Service is to administer grants to schools, which would go only to those which admit students without discrimination on the basis of race, creed, color, or national origin.

The bill further provides $50 million the first year, $60 million the second year, and such sums thereafter as needed, to be apportioned among the states for scholarships, the number of which is to be decided by the surgeon general based on currently available educational facilities. A state agency would be designated by the state legislature to administer the funds. Scholarships would be given without discrimination on the basis of race, color, creed, sex, or religion, to include the cost of tuition, books, and equipment. If the surgeon general so decides, scholarships may include a monthly stipend for maintenance of not over $125 per month per student or more if the student has dependents. GI's currently receiving education and training at government expense are not eligible. Scholarship appointees must agree to serve 5 years in the profession after graduation.

Except as provided, the Federal Government is to have no control over the curriculum or administration of any school or admission of applicants.

A National Council on Education for the Health Professions is to be set up with an advisory function. The Council would comprise the surgeon general as chairman, the commissioner of education, chief medical officer of VA, a medical representative of the Secretary of Defense, and 20 members appointed by the surgeon general as leaders in education, public affairs, and medical sciences, 10 of the 20 to be authorities in medical and public health professional education, including nurse educators. Special advisory and technical committees, including one on nursing, would also be appointed by the surgeon general.

A plan for aid in support of practical nurse

training is also included in S 1453. Annually $15 million is to be appropriated for the development of practical nurse training in the states. The funds would be used to meet the direct costs of maintaining an adequate program of administration, supervision, and teacher-training, of developing proper educational programs, for needed equipment, building maintenance and repair, recruitment of students and teachers, and practical nurse training. Funds would be apportioned among the states. Provisions relating to practical nurse training would be administered by the federal commissioner of education.

School Health Services

Two bills with strong bipartisan sponsorship were simultaneously reported to the Senate on March 25—S 246 (PHN, April 1949, page 219) and the new S 1411 which provides $35 million a year for federal aid to the states in developing school health services in elementary and secondary schools. On the basis that "no American child should come to adult life with physical or mental defects which can be prevented or corrected at an early age," federal funds are authorized to help the states provide periodic health examinations and diagnosis, including dental examinations, for all school children and to provide, at the schools when possible, treatment for conditions found. Whenever the parents are unable to provide it, such treatment would be free. The state plan, however, may provide for prevention and treatment of physical and mental defects of all school children. Special reference is made to the correction of defects and conditions "likely to interfere with the normal growth and development and educational progress of children."

Grants would vary according to the child population between 5 and 17 years and relative per capita income in the states. States must continue to spend not less than the total spent for health services in 1949. Grants are to be made with a matching provision, the richer states on a sliding scale to provide more state and local funds in relation to federal funds received than the poorer states.

A comprehensive state plan is to be prepared jointly by the state education and health agencies, and administration under the act would be under one or both as agreed upon. The program under the act can, at the option of the state, be administered in conjunction with the rest of its child health program. There is to be a state advisory committee which includes representatives of both official and nonofficial interested agencies. The school health services would use already existing qualified services within the state. Provision is also made for cooperation with medical, nursing, educational, and other groups concerned. There are to be working agreements with official agencies caring for handicapped and crippled children. The federal security administrator would pass on the adequacy of state plans and otherwise administer the act on a federal level through units of FSA he might designate. The state plan must be in full force by October 1, 1952.

Both public and non-profit-non-public schools would benefit under the act, including schools maintained for minority races.

Old Age and Survivors' Insurance

Hearings have been held by the House Ways and Means Committee on HR 2893, an Administration supported bill to extend the benefits of OASI and to add protection against disability for employees of non-profit organizations, and others not now covered by Social Security. The bill provides for a tax of 2 percent of wages on both employee and employer after January 1, 1950, but contains the proviso that while the employee's tax shall be compulsory, that for employers shall be voluntary. When the employer does not elect to pay the tax the normal benefits are reduced by 50 percent.

HR 2893 would about double present old age benefits and also the payroll tax which is now 1 percent each for employees and employers on the first $3,000 of the worker's pay. The women's retirement age would be reduced from 65 to 60. A retired beneficiary would be allowed to earn up to $50 per month without loss of benefits, instead of the present $14.99.

Another new feature in the bill is the provision for sickness benefits. Covered employees—with due consideration of their

wages and number of dependents—would receive for a short period up to $30 per week for single persons and up to $45 a week if 3 or more dependents. Benefits for extended illness would also take account of length of time in the system. Provisions for dependents are liberalized and benefits increased.

The NOPHN has written Chairman Doughton that it favors the extension of insurance to employees of non-profit organizations, but does not approve the clause making payment of taxes by the employer voluntary. This exemption of employers is urged by certain large universities and church organizations.

Homer Wickenden, secretary of the National Health and Retirement Association, has stated that the Association considers its plan as supplementary to any federal legislation and that "if necessary" the Association would reduce the amount of payments so that the overall cost to agencies of both the federal insurance and the plan would not be much more than the present cost of participation in the plan.

Public Welfare

Closely related to the bill HR 2893 to extend OASI benefits are HR 2892 (introduced by Doughton and supported by the Administration) and HR 2645 (introduced by Forand and incorporating American Public Welfare Association recommendations). The two bills both go under the name of "Public Welfare Act of 1949" but differ in a limited number of ways.

The contributory insurances such as retirement, unemployment, premature death, and illness and disability insurance, toward which both employe and employer contribute, are looked to providing for the common risks of the average man. However, such insurance even if it could cover all the people in an adequate manner (which it is far from doing now) would still not provide benefits adapted to all possible situations or all individual circumstances. There would always be some people outside the system—the already retired person who does not have insurance rights or limited rights, those too ill or disabled to work, children not dependent on a wage earner, and others. As the benefits under social insurance are extended, those in the needy class who require "assistance" would tend to decrease in number.

Representative Forand said in introducing his bill:

> Assistance is the ultimate guaranty, government's assurance to the people that when all else fails—when insurance benefits are exhausted, inadequate, or unavailable; when work is impossible and savings gone; when veterans benefits, and union health and welfare fund provisions, and company pensions, and help from church and philanthropic agencies, and all the other ways we seek to aid each other do not meet the need—the Government will stand behind its people to keep the still-remembered specter of want and privation from the door.

HR 2892 extends federal aid to the states on a basis ranging between 40 and 75 percent of total costs depending on the relative state per capita income. Federal aid is extended to "all needy persons" as well as to the three groups, needy aged and blind, and dependent children which are covered in the present law. Maximum payment in which the federal government would participate would be $50 a month for one person or $50 for each of the first two persons in the home, and $20 a month for each additional person. Another proposed welfare aid is federal aid to the states, within specified limits, when the state has paid the medical bill of a needy person to the doctor or the hospital. Federal aid is also offered to the states for welfare services for adults, families and children, the first year's outlay to be $24 million. The present federal authorization for child welfare services only is $3,500,000.

The Family Service Association of America has announced full support of HR 2892.

See PHN, July 1948, page 338, "Public Assistance as a Community Resource" by Jane M. Hoey.

Public Health Service Annual Appropriations

In HR 3333 the House has approved an appropriation of $165,674,000 for the Public Health Service for the coming year, an increase of about a million over last year. The Senate Appropriations Committee will shortly hold public hearings on the bill which also includes next year's funds for the Children's Bureau. Separate items include $16,000,000 for venereal disease control, $9,550,000 for

tuberculosis, $13,537,000 for mental hygiene, $21,400,000 for cancer, $7,725,000 for heart disease, $13,600,000 for general public health measures and others. The House lowered some specific requests of the President and raised other appropriation items.

NEW FILM ENLISTS NURSES IN CANCER FIGHT

MANY CENTURIES ago Hippocrates wrote about the necessity for finding cancer early if the disease were in any measure to be controlled. This precept has become axiomatic. To the conception of early diagnosis has been added prompt—effective—treatment.

Realizing the important place the nurse holds in the doctor-patient-nurse cancer control team, the American Cancer Society has produced a teaching film, in cooperation with the nursing staff at Memorial Hospital for Cancer and Allied Diseases in New York City, which will be released through the Society's State Divisions May 1.

"What Is Cancer?" is a 16-millimeter color film, with sound, designed as dramatic teaching material for nursing schools, hospitals, and nurse's professional organizations. Running time is 25 minutes.

The primary aim of "What Is Cancer?" is to explain the biology of cancer. The disease poses difficult technical and psychological problems which can be met with assurance when fundamentals are known.

The film opens with a short historical sequence showing some of the earliest records made and some of the earliest treatments devised. It ends with the famous operation performed by Dr. Theodor Billroth in Vienna in 1881 in which, for the first time, a cancer of the pylorus was successfully removed. Billroth's operation was the beginning of the modern surgical attack on cancer.

Cancer can originate in any organ of the body. Animation sequences show the sites of most frequent occurrence. Normal and cancerous tissues are shown, and cell growth, carcinogenic agents, pre-cancerous conditions, the danger signals, and metastatic spread.

By means of animation and time-lapse photography the difference between normal and abnormal cell growth is brought to life. It is pointed out that cancer is not a foreign growth but an abnormal growth of ordinary tissue which can occur anywhere in the body. It is also known that certain chemical agents cause abnormal growth in body cells and the fact of producing cancer experimentally is illustrated. The process of metastatic spread of malignancies through the vascular and lymphatic systems is reproduced in animation and a comparison of primary and metastatic lesions in actual tissues is shown.

The final section of the film is concerned with methods of treatment, the possibilities of reducing the present cancer death rate, the potential of discovering cancer by means of periodic physical examinations, and the psychological approach in the nursing care of both pre-operative and post-operative cancer patients.

Most of these scenes are done from real life. They point up the importance of the nurse in the doctor-patient-nurse cancer control team. It is frequently the pleasant, concerned attitude of the nurse that elicits a recital of seemingly inconsequential symptoms from the patient which may mean cancer. And it is frequently her attitude of encouragement that keeps the hospitalized patient in good psychological health.

"What is Cancer?" was produced by Audio Productions, Inc., 630 Ninth Avenue, New York, N. Y., from whom prints of the film may be purchased by any professional nursing or medical individual or group.

It is the hope of the American Cancer Society that the film will be widely used. For this reason, it will be made available for loan through the local divisions of the Society. Information may be had from the national office by writing Marjorie E. Schlotterbeck, nursing consultant, 47 Beaver Street, New York 4, N. Y.

KATHERINE E. NELSON, R.N.
CHAIRMAN, ADVISORY NURSING COMMITTEE
AMERICAN CANCER SOCIETY

DENTAL SURVEY GOES TO SCHOOL

HERVIDA DOMAS, R.N.

CHILDREN enjoy contests, be it bubble gum blowing or model airplane building. By planning a contest in brushing of teeth as well as dental corrective work in our schools we have awakened all who participated to the great need in the care of children's teeth to safeguard them from toothache and unnecessary dental bills.

Several parents, teachers, and nurses have inquired about the dental program in our school system which has proven so helpful in promoting better health habits and better dental care with practically no cost. This program is especially adaptable to communities where one nurse is working without the aid of dental mobile units and dental hygienist, and must receive help from local dentists. With us it has become a yearly event and a very important part of the school health program.

I would like to take you with me step by step as plans and preparations are made for the survey and final campaign.

The dentists are approached several months before the date set for the survey so they will make no appointments on the special days they give the schools. In our city with a student enrollment of about twenty-five hundred, it is necessary for all dentists to work two mornings. In the schools of four hundred enrollment, two dentists make the examinations between the hours of nine and twelve o'clock. In schools with a larger enrollment it is necessary to have three dentists working.

Mrs. Domas, retired after many years in school nursing, now lives in Long Beach, California.

Individual school faculties are visited; teachers instruct the children as to their particular dental survey. All preparations are made to the smallest detail, so everything moves as smoothly as clockwork on the day of the examinations.

Two dental slips, as shown below, are filled out for each child by the teacher in the lower grades. The older children fill out their own, but they must have them in readiness when they are called to the clinic room.

City, State

.....

Month, Date, Year

.....

Child's name

..... dental examination

Name of school

at .....grade ..... reveals the following:

Cavities in baby teeth .....
Cavities in permanent teeth .....
In need of straightening .....
In need of cleaning .....
Extractions .....
X-Ray .....

We advise you to take your child to your family dentist for immediate care of defects checked above.

School Dental Clinic

.....

Three helpers, two recorders and one page, are chosen by the teacher of the highest grade, based on their ability to concentrate, take orders clearly and not talk too much. Each recorder is seated at a table directly behind the dentist's chair, equipped with several well

sharpened pencils, a good eraser, and several paper clips.

For equipment we use two portable dental chairs; three high tables with 18- by 24-inch tops for the instruments and glasses of antiseptic solution; and sterile water for washing off the antiseptic solution. Needing a third dental chair, we found that an old discarded swivel chair placed on a small platform answered the purpose very well.

Each dentist brings his own instruments. After each examination the instruments are placed in the antiseptic solution then into a glass of hot water, the solutions being changed continuously. A wash basin of warm water, a bar of soap, small hand brush and a finger nail file are placed conveniently for the use of each dentist, and this water is changed frequently. We have never had a complaint nor an infection following an examination. The few times we have found serious mouth infections everything has been removed from the table and boiled.

A tea kettle on a small electric plate in a near-by wash room provides the boiling water necessary. Bath towels are used for wiping hands and huck towels are used on the tables and to wipe off instruments.

With all the preliminaries taken care of we are ready for one week of dental examinations. The dentists arrive a few minutes before nine o'clock so all is in readiness when the first class walks in. We start with the kindergarten and work on up through all the grades until all have been examined.

The teacher comes with her pupils, each child holding his two dental slips. The children are grouped in two lines one line back of each dentist's chair. As they step into the dental chair they hand the two slips to the recorder, who checks on the slips whatever the dentist calls out. If the mouth is found to be in perfect condition a star is placed in the right hand corner of the slip. As the child leaves the chair one slip is handed to him to take home to his parents at the close of the day, the other becomes the school record. Upon completing one grade, all slips are clipped together with the teacher's name on the first slip.

One week following the dental survey we start with the dental campaign which we promote in all the elementary grades, checking daily for four weeks, striving for better health habits as well as corrective dental measures.

Each teacher has a large chart in her room on which are written the names of the children. Opposite each name 20 spaces are drawn, allowing a space for each day. The space for each day is again divided into two spaces, a blue check is given for clean hands, face, neck, ears, combed hair, and clean finger nails, and a red check for brushed teeth. Each check stands for one point or two points for a day if a perfect score. This will total 40 points in 4 weeks. We give 60 points for an OK received at the time of the survey or when the child has had his dental work completed. At the close of the campaign a perfect score is 100 points.

The checking stops at the end of the fourth week but the habits established carry over for several months. Some special acknowledgment is given all children who have had their dental work completed.

The children who can not afford to have their dental work done are taken care of, the work paid for through a fund set aside for that purpose. The dentists give us a morning for a very reasonable price using their own equipment and materials; this service is rotated. The children are brought from school to the dentist's office by their parents or the school nurse.

If you talk with your local dentists I am sure you will find them willing to help you get this program started. It was during the lean years when dentists were taken off the school payroll that our local dentists who were very interested in dental education made this program possible for us. They came to the public schools with their own instruments and made examinations on all the children free of charge.

Although conditions have improved this dental survey is still conducted according to the first arrangements. It has created a great deal of interest. The children as well as parents have become tooth conscious. Many children have better health because of better teeth and a child's absence from school because of toothache is almost unknown.

SUMMER COURSES FOR PUBLIC HEALTH NURSES

Summer Courses in Universities Having Programs of Study in Public Health Nursing Accredited by the National Organization for Public Health Nursing

California

Berkeley. University of California. June 20-July 30. The Field of Public Health Nursing.
For further information write to Department of Nursing, 3578 Life Sciences Building, Berkeley 4, California.

Los Angeles. University of California. June 20-August 13. Family Case Work as Related to Public Health Nursing—Mrs. Beatrice Sommers, Case Supervisor, Veterans Administration Mental Hygiene Clinic; Development and Principles of Public Health Nursing—Ann Finch, Director, Bureau of Public Health Nursing, Los Angeles County Department of Health; Maternal and Child Health—Edith Eyster, Consultant in Child Health, Los Angeles County Department of Health; Study of Nursing Education—Lulu K. Wolf, and Dr. Esther L. Brown, Director, Department of Studies in the Professions, Russell Sage Foundation; Curriculum Construction; Special Problems in Nursing—Anne Austin, formerly of Western Reserve University, and Dr. Genevieve Bixler.
For further information write Summer Sessions, University of California, Los Angeles 24.

Colorado

Boulder. University of Colorado. June 16-August 26. Public Health Administration; Principles of Public Health Nursing; General Public Health Nursing Field Practice; Principles of Supervision in Public Health Nursing. June 16-July 22. Problems in Public Health Nursing.
For further information write to Mrs. Pearl Parvin Coulter, Associate Professor of Public Health Nursing.

District of Columbia

Washington. The Catholic University of America. June 27-August 6. School Health Problems; Principles and Methods of Teaching as Applied to Public Health Nursing; Communicable Disease Control; Orthopedic Nursing; Psychobiology; Principles of Public Health Nursing.
For further information write to Janet F. Walker, Director, Division of Public Health Nursing.

Illinois

Chicago. Loyola University. June 28-August 5. Principles and Organization of Public Health Nursing; Morbidity Program; Public Health Nutrition; Field Work in Public Health Nursing; Principles of Health Teaching; School Health Problems. June 13-18. Workshop on Field Training for Public Health Nursing Personnel—Anna Heisler, Associate Chief, Office of Public Health Nursing, USPHS, leader. For consultants, educational directors, supervisors, and staff nurses participating in teaching public health nursing personnel. Registration fee $25.
For further information write to Dean, School of Nursing, Loyola University, 820 N. Michigan Avenue, Chicago 11.

Chicago. The University of Chicago. First term, June 27-July 29; Second term, August 1-September 2. Principles of Public Health Nursing; Special Fields in Public Health Nursing; Field Work: Public Health Nursing; The Teaching of Health; Social Case Work I; Supervision in Public Health Nursing; Field Work: Supervision or Administration in Public Health Nursing.
For further information write to Nellie X. Hawkinson, Nursing Education, 5733 University Avenue, Chicago 37.

Indiana

Bloomington. Indiana University. June 14-August 12. Principles of Public Health Nursing; Public Health Organization; Content Materials in General Nursing; Teaching in Nursing; Guidance in Nursing; Advanced Principles in Public Health Nursing; Field Work in Public Health Nursing; Introduction to Principles of Orthopedic Nursing (Medical Center, Indianapolis); Jurisprudence and Legislation Affecting Nursing.
August 11-August 27. Workshop on School and Community Health.
For further information write to Mrs. Eugenia K. Spalding, Director, Division of Nursing Education.

Massachusetts

Boston. Simmons College. June 27-July 15. Survey of Methods; Principles of Public Health Nursing; Control of Communicable Disease; Instructor Training in Red Cross Home Nursing.
July 18-August 5. Principles and Methods of Comprehensive Care; Public Health Nursing Organization and Administration; Supervision in Nursing; Principles of Guidance Applied to Nursing.
For further information write to Director, School of Nursing, 300 The Fenway, Boston 15.

Michigan

Ann Arbor. University of Michigan. June 20-July 2. Two-week, non-credit orientation and refresher course on public health nursing services. June 20-July 9. Cancer Nursing. June 20-July 30. Introduction to Supervision in Public Health Nursing; Regular courses in the School of Public Health and the School of Education. July 11-July 30. Orthopedic Nursing—Helen Lehman, guest instructor. June 20-August 13. Regular courses in the College of Literature, Science and the Arts and eight-week courses in the School of Education.

For further information write to Ella E. McNeil, Professor of Public Health Nursing, School of Public Health, Ann Arbor.

Minnesota

Minneapolis. University of Minnesota. June 13-25. Workshop in Mental Hygiene for Staff Nurses. July 5-22. Workshop on Integration and Health Aspects of Nursing—Mary Dunn and others.

For further information write to Margaret S. Taylor, Director of Course in Public Health Nursing, School of Public Health.

Missouri

St. Louis. St. Louis University. June 21-July 29. Principles of Public Health Nursing; Maternal and Child Health.

For further information write to Helen E. Kinney, Director, Division of Public Health Nursing, 1325 South Grand Boulevard, St. Louis 4.

New Jersey

Newark. Seton Hall College. June 27-August 5. Principles of Public Health Nursing; School Nursing; Introduction to Supervision in Public Health Nursing; Prevention and Control of Tuberculosis; Nutrition and Health; Mental Hygiene; Educational Psychology; Biology; Child Growth and Development.

For further information write to the Director, School of Nursing Education, 40 Clinton Street, Newark 2.

New York

Buffalo. University of Buffalo. July 5-August 13. Principles of Public Health Nursing I; Teaching in Public Health Nursing.

For further information write to the School of Nursing, 25 Niagara Square, Buffalo 2.

New York. Columbia University, Teachers College. June 30-August 13. Work Conference on Problems of Health Teaching; Scope and Functions of Public Health Nursing; Preventable Diseases; Mental Hygiene in Nursing; Orientation to Social Work in Family and Community Welfare; and other related courses; Materials and Methods of Supervision in Public Health Nursing (second course); Public Relations in Nursing; and other related courses.

For further information, new students write to Admissions Office, Teachers College, 525 West 125th Street, New York 27; old students notify Admissions Office of interest to study during the Summer Session.

New York. New York University June 7-July 1. Applied Bacteriology for Health Supervisors; Field work in observation and practice in the following areas,—public health nursing in official agency—public health nursing for school nurses, teachers of home hygiene and child care and industrial nurses; observation and practice in supervision in public health nursing.

July 6-August 12. Principles of Public Health Nursing I; Principles and Methods of Teaching; Introduction to Social Case Work; Advanced Principles and Problems of Teaching in Nursing Education; Teaching Activities of the Public Health Nurse; Applied Nutrition for Health Supervisors; The Dynamics of Supervision in Nursing.

August 15-September 9. Courses in allied fields in other departments.

For further information write to Assistant Professor Amy M. Erickson, Director of Programs in Public Health Nursing, Department of Nursing Education, School of Education, New York 3.

Syracuse. Syracuse University. July 5-August 12. The following courses which are a part of the regular program of study for a B.S. degree with a major in public health nursing are being offered: Principles in Public Health Nursing; Public Health and Statistics; Field Practice in Public Health Nursing; Maternity and Child Hygiene; Role of the Nurse in Public Health Services; Nursing in Schools; Preventable Diseases; Case Work Methods; Methods of Learning Health Applied to Public Health Nursing. June 6-June 18. Special Workshop and Institute in Principles and Methods in Public Health Nursing Field Practice. Workshop in Teaching Principles of Posture and Body Mechanisms—Lois Olmsted and Louise Suchomel, consultants for the Joint Orthopedic Nursing Advisory Service.

July 25-August 14. Workshop in the Problems of the Cerebral Palsy Child—Mary Elinor Brown, Workshop coordinator consultant in physical therapy, New York State Association for Crippled Children. July 5-July 15. Third Community Nutrition Institute, sponsored by Syracuse University and New York State Department of Health. Anne Bourquin, Chairman, Department of Foods and Nutrition, and Margaret Queneau, Associate Nutritionist, New York State Department of Health.

For further information write to Ruth E. TeLinde, Director, Department of Public Health Nursing, College of Medicine.

North Carolina

Chapel Hill. University of North Carolina. July 25-August 26. Special Fields in Public Health Nursing: Cancer—Katherine Nelson, Columbia University, guest instructor; Tuberculosis—Mrs. Louise Lincoln Cady, Coordinator of Nursing Education in Connecticut State Sanatoria; Orthopedics—Helen Kaiser, Director of Physical Therapy, Duke University School of Medicine; Mental Hygiene—Ruth Gilbert, Coordinator of Program for Nurse Mental Hygiene Consultants, Columbia University; Geriatrics—Dr. George Lawton.

For further information write to Ruth W. Hay, Professor, Box 229.

Ohio

Cleveland. Western Reserve University. June 20-July 30. Principles of Public Health Nursing; Adult Health; Principles of Public Health; Nursing in Tuberculosis; Nursing in Venereal Diseases; Methods of Learning Health in Public Health Nursing. July 11-July 29. Social and Health Aspects in Basic Professional Education—Irene Carn, guest instructor.

For further information write to Ellen L. Buell, Director, Programs in Public Health Nursing.

Oregon

Portland. University of Oregon. June 27-September 10. Regular summer sessions.

July 11-23. Special course in maternity nursing. Margaret Thomas, Nursing consultant, Children's Bureau.

For further information write to: Henrietta Doltz, Director, Department of Nursing Education, 3181 S.W. Marquam Hill Road, Portland 1.

Pennsylvania

Philadelphia. University of Pennsylvania. June 27-August 6. Maternity, Infancy and the Preschool Child; School Nursing; Case Work Approach to Problems of School Children.

For further information write to Katharine Tucker, Director, Department of Nursing Education, 3810 Walnut Street, Philadelphia 4.

Pittsburgh. Duquesne University. June 23-August 6. Principles of Public Health Nursing and School Nursing. Also academic subjects required for a certificate in public health nursing and for bachelor of science degree in Nursing Education with a major in public health nursing, such as: Principles of Chemistry, Sensory Aids, Sociology, Psychology, History of American Democracy, History of Pennsylvania, English.

For further information write to Mary V. Adams, Director, Public Health Nursing.

Pittsburgh. University of Pittsburgh. June 27-August 5. School Nursing; and other courses to meet the requirements for a school nurse certificate in Pennsylvania.

For further information write to School of Nursing, University of Pittsburgh, Pittsburgh 13.

Tennessee

Nashville. George Peabody College for Teachers. June 13-August 19. Introduction to Public Health Nursing; Nutrition and Health; Mental Health; Public Health Administration; Supervision in Public Health Nursing; School Health Education; Public Health Statistics; Field Work in Public Health Nursing.

For further information write to Edna Lewis, Director, Public Health Nursing.

Nashville. Vanderbilt University. July 11-23. Teaching of Body Mechanics in Nursing.

For further information write to Office of the Dean, School of Nursing, Nashville 4, Tennessee.

Texas

San Antonio. Incarnate Word College. First term, June 7-July 10; Second term, July 20-August 31. Introduction to Public Health Nursing; Maternal and Child Health; Field Experience in Public Health Nursing. Courses satisfying requirements for the B.S. degree in public health nursing will be offered in all departments of the College of Arts and Sciences.

For further information write to the Registrar, Incarnate Word College.

Virginia

Richmond. Medical College of Virginia. June 1-15. Workshop in Supervision in Public Health Nursing—Hazel Higbee, guest instructor.

For further information write to C. Viola Hahn, Director, Program of Study in Public Health Nursing.

Washington

Seattle. University of Washington. June 20-August 19. All regular courses in public health nursing, clinical specialties, nursing arts, teaching and administration. Survey of Orthopedic Conditions and Nursing Problems—Kathleen Newton, Cornell University-New York Hospital, guest professor.

July 5-15. Principles of Posture and Body Mechanics in Planning Nursing Care—Miss Newton. June 20-July 20. Health Education—Dr. Dorothy Nyswander, University of California School of Public Health.

For further information write to Dean Elizabeth S. Soule, School of Nursing.

(Continued on page 301)

TRENDS IN MEDICINE AND PUBLIC HEALTH

UNIFORM BIRTH NUMBERING SYSTEM

A new system of numbering birth certificates based on a uniform and nationwide level, and recommended by the American Association of Registration Executives and the Association of State and Territorial Health Officers, is one other development in streamlining the bureaus of vital statistics in the state departments of health. It went into effect January 1, 1949 in all but one state (Connecticut started it January 1, 1948).

The birth number consists of 11 digits divided into three segments. The first block of three refers to the state or area of birth (e.g. the number assigned to Connecticut is 106; to Massachusetts, 120; to New York, 131; and to New York City, 156); the next two numbers consist of the last two digits of the year of birth; and the last block of six digits relates to a serial registration number assigned in the area where the birth occurred. For example, a child born in Berlin, Connecticut, January 5, 1948 has the birth number: 106-48-000001.

The establishment of this system opens up interesting possibilities for the future. It will be the identifying mark of every individual, and the number will be used for all documents now requiring birth certification, such as school entrance, working papers, motor vehicle operator's license, passports, entrance to military service, social security benefits, and marriage.

PREGNANCY TESTS

A critical review of present-day pregnancy tests by Dr. Stanley L. Robbins of Boston appears in the August 2 and September 2, 1948 *New England Journal of Medicine*. The author states that no perfect pregnancy test exists, and that it is impossible at this date to select any one existent procedure as best.

For as far back as written records take us, there is evidence of the performance of pregnancy tests. One basic concept persisting down to the 16th century, was the idea that urine from pregnant women stimulated plant growth, and early tests were based on that principle. The search for improved testing methods was constant, but it was only in the early 20th century, through the pioneer work of Evans and his associates (Smith and Engle; Aschheim and Zondek), that the present era of accurate pregnancy diagnosis was made possible. The demonstrations by these early workers of the complex inter-relation between the ovary and the pituitary body and the urinary reaction of these hormones produced for the first time the tools necessary for basing pregnancy diagnosis on sound scientific grounds.

Basically all the common pregnancy tests consist of animal assay methods of detecting in the urine or blood stream the high levels of hormone produced during pregnancy. These tests rest upon two fundamental facts: (1) during pregnancy there is an increase in either the production or the excretion of these hormones and (2) these hormones produced by the human female will effect demonstrable changes in lower animals. The three animals most widely used for laboratory diagnosis of pregnancy have been the mouse, rat, and rabbit. Each of these animals reacts in a characteristic fashion to the administration of gonadotropic hormone—mouse and rabbit by the formation of corpora hemorrhagica, and rat by the formation of cystic follicles that later become luteinized.

A positive test does not necessarily imply a living fetus, nor does it distinguish between normal or abnormal pregnancies or tumors

containing chorionic epithelium. It is possible in cases of intrauterine fetal death or abortion to have a positive pregnancy reaction for some time. False negatives may obtain when the test is performed before the prolan titer has had time to rise to a detectable level.

In general either blood serum or urine may be used in these diagnostic procedures.

Some of the more generally recognized tests are summarized below:

The *Aschheim-Zondek* test (first appearing in 1928) is one of the most widely used and accurate technics. As originally described, it employs immature mice weighing 8 gm. and approximately 3 weeks of age. Filtered morning urine, in amounts of 1.8 to 2.4 cc, is administered to each mouse in individual doses 3 times daily for 2 days. Ninety-six hours after the first injection the animals are "sacrificed" and their ovaries examined for "blutpunke" or corpora hemorrhagica, a change produced by the presence of chorionic gonadotropin in the urine. In some laboratories the immature rat is substituted for the mouse because of a greater sensitivity to the hormone and resistance to the toxic factors. After dosage for 3 days the animal is sacrificed on the 5th day and examined for follicle formation and corpus luteum formation. Corpora hemorrhagica are rarely found in the rat. The results with this test are universally reported excellent. Aschheim, in 1935, cited his accuracy as 98 percent in positive reactions and 99.5 percent in negative tests. The sole drawback, aside from the necessity of maintaining rodents of proper size and age, has been the time required for the performance of the test—4 or 5 days.

The *Friedman test*, a modification of the original mouse test, employs rabbits rather than mice. It is based on the principle that "female rabbits ovulate only upon stimulation by the male and, therefore, do not spontaneously ovulate or have corpora hemorrhagica." Its great advantage over the Aschheim-Zondek test is its relative speed—48 hours as compared to 4 or 6 days. The drawbacks are: (1) It is necessary to have constantly at hand a colony of isolated, relatively large female animals, each weighing 3 to 4 pounds. (2) The animals are very sensitive to toxic urines and are easily killed. (3) Occasional focal hemorrhages that occur may closely resemble true ovulatory hemorrhages, making the test difficult to read.

As for the *Ovarian Hyperemic test*, one of the first effects of chorionic gonadotropin on the ovaries of immature rats is the development of a superficial hyperemia. This change appears within 2 hours and reaches its peak in 16 to 24 hours. On the basis of this ovarian color change, numerous procedures have been developed—the 2-, 6- and 24-hour rat test. At 2 hours the change is subtle and is based on a comparison of the faint hyperemization of the ovary with the pale serosa of the other viscera. The danger exists of receiving false-negative results because of a possible nonspecific inflammatory reaction of the other viscera, as high as 45 percent. Even the 6- and 24-hour tests have failed to gain wide acceptance because of the difficulty in reading the endpoint. This test is considered of limited value in most laboratories.

The frog test, popularized in the United States in 1941 by Weisman and Coates following earlier work by other researchers, has received enthusiastic support. Its accuracy has been cited as between 96 and 100 percent. The test is based on the fact that the *Xenopus laevis*, like the rabbit, never ovulates unless stimulated by the male or by the administration of gonadotropic hormone. The isolated female frogs, when injected with urine from pregnant women, react to a positive test by the extrusion of hundreds of grossly visible ova, usually in 24 and occasionally in 48 hours. After an appropriate rest, the animal can be reused throughout a 10- to 11-year period. Its advantages are (1) endpoint is definite and simple to read—presence or absence of ova (2) the speed exceeds that of the Friedman test (3) reuse of the animals and their ease of maintenance makes the procedure adaptable and cheap. The sole remaining objection to the widespread use of this technic is the need to obtain and concentrate large volumes of urine, 40 to 80 cc, for each frog.

In the course of breeding experiments it was noted that the male frog was more sensitive to chorionic gonadotropin than the female, smaller quantities of urine—10cc sufficing to

produce a reaction in the South American *Bufo arenarum*, and 5 cc in the North American male *Rana pipiens*. At present the male frog tests hold the greatest promise. Animals are widely available, easy and cheap to maintain, and a diagnosis can be returned while the patient waits.

Of the several chemical procedures reported to be of use in the diagnosis of pregnancy, the only one that appears to hold any great promise is the *Pregnanediol test* developed by Guterman. It is based on the observation of Venning and Browne that pregnanediol is present throughout pregnancy although in low concentration in the first trimester. The test is an extraction of the acid hydrolyzed pregnanediol and the development of a color complex by addition of sulfuric acid. Reports of its accuracy are somewhat equivocal, and it has the fundamental disadvantage of dealing with the lowest titer of hormone when early diagnosis is required. In conditions other than pregnancy associated with a high gonadotropic excretion, such as moles and chorionepitheliomas, this test is very useful since it is said to remain negative and therefore to differentiate these conditions from pregnancy.

DENTAL DECAY IN ADULTS

Convincing evidence is available to show decreased dental caries in children in areas in which water supplies contain at least 1 part per million of fluorine. No information has existed, however, on the dental condition of adults who acquired dental fluorsis, due to excessive fluorine intake, in childhood.

Dr. F. S. McKay of Colorado now reports on the dental status of 400 lifelong residents of Colorado Springs who had regularly used the water supply which consistently maintains a fluoride level of 2.6 p.p.m. Mild mottling of the enamel due to fluorine was found in 137 of the first 300 subjects studied. Of the total 400 subjects of all age groups over 10 years, 35 percent showed no decay experience whatever, while there was an average of 2.98 decayed and filled teeth per person, and a mean of 0.25 teeth lost due to all causes. In the 15 to 19-year-old age group there was a total of but 5 teeth lost in all of the 89 persons examined and only 1.51 decayed or filled teeth per person. These figures are to be contrasted with the estimated average experience of 7 fillings and 2 extractions for the 16-year-old age group in the United States as a whole.

In tooth loss, standardized rates in the country, weighted according to economic distribution, range from 1.2 to 10.2 extractions per person in age groups from 15 to 19 and 40 to 44 years, respectively. The corresponding tooth loss in Colorado Springs ranged from 0.05 to 0.61 teeth per person in the same age groups.

It seems justifiable to conclude that continuous exposure to a water supply containing 2.6 p.p.m. of fluorine greatly reduced the caries rate and tooth loss of adults. It was also found that the protective effect of fluorides ingested during the formative stage of the tooth may be in evidence in adult life even though the ingestion of high fluoride water is not continued.

Summer Courses for Public Health Nurses

(Continued from page 298)

Wisconsin

Madison. University of Wisconsin. June 27-August 19. Principles of Public Health Nursing; Special Sources in Public Health Nursing; Maternal and Child Health.

For further information write to Martha Jenny, Associate Director, Public Health Nursing, 1402 University Avenue, Madison.

Milwaukee. Marquette University. June 20-July 29. Principles of Public Health Nursing; School Health Problems; Maternal and Child Health; Tuberculosis Nursing; Venereal Disease Nursing; Public Health Administration.

For further information write to Anna Hassels, Director of Program of Study in Public Health Nursing, College of Nursing, 3058 N. 51st Street, Milwaukee 10.

IN MEMORIAM

Death, be not proud, though some have called thee
Mighty and dreadful, for thou are not so.
For those whom thou think'st thou dost overthrow
Die not, poor Death.

—JOHN DONNE

During the past months these nurses and friends of nursing died. Our need for them was great, our loss of them is grievous. Yet we are thankful they lived and served.

Mrs. Hazel Radley Barton, June 14, 1948, Waupaca, Wisconsin.

Mary F. Benedict, 1948, New York, N. Y.

Mary Benton, January 7, 1949, Mt. Holly, New Jersey.

Helen E. Bond, March 29, 1949. Director of Nursing Service, Chatham-Savannah Health Council, Savannah, Ga.

Mrs. Gertrude E. Brown, June 1948, Pittsfield, Massachusetts.

Dorothy F. Buck, February 8, 1949, Wendover, Kentucky.

Ida F. Butler, March 11, 1949, Hartford, Connecticut. Former national director of the American Red Cross Nursing Service.

Rose K. Butler, December 26, 1947, Holyoke, Massachusetts.

Nona Charles, July 26, 1948, Harrison, New York.

Mrs. Charlotte Chilson, May 1948, Highland Park, Maryland.

Taliaferro Clark, M.D., July 4, 1948, U. S. Marine Hospital, Ellis Island, New York. Former assistant surgeon general of the Public Health Service.

Eva L. Crowell, January 14, 1948, Walla Walla, Washington.

William Darrach, M.D., 1948, New York, N. Y. A member of the NOPHN Advisory Council.

Agnes Gardiner Shearer Deans, March 14, 1948, Oswego, New York. A pioneer in public health nursing in Michigan, and in the development of professional organizations.

Mrs. Florence Dunwiddie, January 31, 1949, Delavan, Wisconsin.

Ada R. Eichbaum, 1948, San Leandro, California.

Mrs. Avis Lynell Davis Everhart, February 12, 1948, Raleigh, North Carolina.

Elizabeth Glasheen, January 18, 1948, Worcester, Massachusetts.

Paula Gray, 1948, Martinez, California.

Eva Mae Hardin, July 2, 1948. Instructor in public health at Baylor University School of Nursing. See PUBLIC HEALTH NURSING, October 1948, p. 527.

Mrs. Robert Hill, January 1947, Grand Rapids, Michigan.

S. McC. Homill, M.D., May 3, 1948, Philadelphia, Pennsylvania.

Louise Johnson, February 3, 1948, York, Pennsylvania. Supervisor of school nursing with the York VNA.

Mrs. Corinne Jones, 1948, Chicago, Illinois.

Mrs. Irene W. Kryssak, November 12, 1947, Buffalo, New York.

Mrs. Mathild D. Krueger Lamping, March 17, 1948, Neenah, Wisconsin. A pioneer rural school nurse in Northern Wisconsin and the Carolinas.

Helen Libby, April 1948, Santa Cruz, California.

Mrs. Lea McI. Luquer, June 8, 1948, New York, N. Y.

Mrs. Jessie R. McClain, 1948, Annandale, Virginia.

Mrs. Bradford O. McIntire, March 1948.

Mary A. Meyers, March 5, 1948, Indianapolis, Indiana. Helped to establish the first fresh air school in Indianapolis, and to plan mass chest x-raying of students and industrial workers in Marion County. Formerly president of Indiana SNA.

James Alexander Miller, M.D., July 29, 1948. One of the founders of the NTA, and its president from 1921-1922.

Rachael Ann Miller, April 3, 1949. Director of the New York Diet Kitchen Association and a public health nurse.

Christina Cameron Murray, 1948. Director of the University of Wisconsin School of Nursing.

Elizabeth G. Neary, August 5, 1948, New York, N. Y.

Agnes M. Nelson, November 23, 1947, Portland, Maine.

Laura Niblock, December 29, 1947, Yadkinville, North Carolina.

Charles F. Nicholson, 1948, Newark, New Jersey.

Mary Adelaide Nutting, October 3, 1948, New York, N. Y. See PUBLIC HEALTH NURSING, November 1948, p. 568.

Dame Rosalind Paget, August 19, 1948, Sussex, England. Founder of *Midwives Chronicle and Nursing Notes*, England's first nursing journal, of which she was editor from 1887 to 1939. Important in the founding of the Midwives Institute, now the Royal College of Midwives.

Nellie Irene Price, September 12, 1948, Frederick, Maryland.

Dorothea B. Robider, March 19, 1948, Baltimore, Maryland.

Mrs. Leotha M. Daniels Schlicht, June 30, 1947, Toledo, Ohio.

Frances D. Sell, July 24, 1948, Cleveland, Ohio. Assistant professor of pediatric nursing at Frances Payne Bolton School of Nursing since 1944.

Sophia Shepreaux, January 18, 1948, Milwaukee, Wisconsin.

Edith L. Soule, October 9, 1948, South Portland, Maine. A pioneer public health nurse and a life member of NOPHN.

Ethel Smith, February 28, 1948, Craigsville, Virginia. Director of the School of Nursing and Administration of Norfolk Protestant Hospital, and director of the Norfolk VNA.

Julia C. Stimson, Colonel, U. S. Army, September 30, 1948, Poughkeepsie, New York. See PUBLIC HEALTH NURSING, November 1948, p. 568.

Cecilia S. Syolfson, September 23, 1947, Cavalier County, North Dakota. State public health nursing supervisor.

Louise M. Tattershall, November 27, 1948. NOPHN staff member from 1924 to 1934; ANA staff from 1938 to 1945; and the National Nursing Council for War Service in 1946.

Mrs. Leslie P. Thompson, December 1947.

Maria L. Tinawin, April 22, 1948, Philippines. Director of Philippine Red Cross Nursing Service from 1932 to 1945.

Clara M. Tuttle, 1948, Berkeley, California.

Mrs. Gordon Wagenet, October 1948, Washington, D. C. Formerly executive secretary of the National Maternal and Child Health Council.

Mrs. Mary D. La Cavalier Warner, April 5, 1948, Salt Lake City, Utah.

Ella Weir, August 10, 1948, St. Louis, Missouri. Executive secretary and registrar in District 1 of the Missouri SNA from 1930 to 1945.

Orpha L. White, November 14, 1948, Waukegan, Illinois. Executive secretary of the Lake County Tuberculosis Association.

Mrs. Daisy Young, February 2, 1948, Tampa, Florida. Charter member of the Florida SACGN.

ROUTINE AUDIOMETER TESTING

The routine audiometer testing of persons over five years of age coming for health examinations to Judson Health Center has resulted in some interesting findings. In 1948 out of a total of 1,415 persons tested, 182, or 12.8 percent, were found to have an abnormal loss of hearing. Of this number, 117 persons had an abnormal loss in one ear only; 65 had such a loss in both ears, and of these only 40 were over 50 years of age.

A man unable to hear a certain pitch was found to be working on a factory assembly line which was very noisy on that pitch. This fact was reported to the industry so that steps could be taken to alleviate the noisy working conditions which had apparently caused or aggravated this man's loss of hearing.

A woman who did not realize that she was hard of hearing was discovered to have an abnormal loss of 50 decibels in both ears, an ear condition which she acquired, she said, when she worked as a telephone operator and attributed to wearing tight ear phones for long periods. When told of the loss of hearing, she realized the cause of friction in the home, since her husband complained that she paid no attention to him when her back was turned. Had her defective hearing been recognized while she was working, corrective steps might have been taken and workmen's compensation might have been in order.

In many communities school children are tested routinely, but adults seldom have this advantage and are tested only when there is an obvious loss of hearing. This might have been prevented or retarded by early recognition and appropriate treatment.

The findings resulting from these routine hearing tests would seem to justify the recommendation that all persons should have a periodic audiometer test as part of a health examination.

ELLEN E. BLACK, R.N.
ADMINISTRATIVE DIRECTOR
JUDSON HEALTH CENTER,
NEW YORK, N. Y.

NEW BOOKS
AND OTHER PUBLICATIONS

NURSING FOR THE FUTURE

A report prepared for the National Nursing Council. New York, Russell Sage Foundation, 1948. 198 p. $2.00.

A PROGRAM FOR THE NURSING PROFESSION

By The Committee on the Function of Nursing. New York, Macmillan, 1948. 108 p. $2.00.

The fall of 1948 brought two outstanding publications on nursing. The first of these was written by a social anthropologist, Esther Lucile Brown, following conferences and study with large and widely representative national groups. The second was written by an economist, Eli Ginzberg, as a report of the committee of six, the members of which brought "experienced judgment to bear on concrete and up-to-date information." The study made by Dr. Brown was initiated for the purpose of determining who should organize, administer, and finance professional schools of nursing. The study reported by Dr. Ginzberg was made for the purpose of "reviewing a selected group of problems centering around the current and prospective shortages of nursing personnel."

As the approach of the Brown report is first to depict the probable nature of health services in the second half of the twentieth century, and then to discuss the nursing services likely to be demanded by those health services, the conclusions and recommendations of the two reports are in certain respects not dissimilar. Both studies emphasize comparable needs for greatly increased numbers of nursing personnel to meet the demands of the health services of the future; for a more definite differentiation of nursing services with an evolving pattern which includes only the professional and the practical nurse; for a broader program of licensure which will give truly adequate protection to the public, and to the practitioners in nursing; for improved working conditions, including better working conditions and a more democratic organization for nursing services; for clarified and improved relationships between the professional nurse and other members of the medical and health teams; and for a plan for improved nursing service through the use of practical nurses as members of a nursing care team.

As would be expected from the objectives of the two, the Brown report places more emphasis on nursing education; the present status of nursing education; the weakness of the existing system of accreditation for schools of nursing; the need for a vital accrediting program; the weakness of an educational system which is financially dependent upon service agencies and inadequate facilities; the possibility of a plan for nursing education which would provide more large, well equipped, and geographically better distributed schools; the necessity of new patterns for basic curriculums; the place of the professional school of nursing in the university, and the practical nurse school in the vocational education system; the financial support needed to make possible a sound system of nursing education. Both reports emphasize the need for experimentation and research in nursing and in nursing education. The Brown report, appropriately, emphasizes the need for nursing organizations to cooperate in or to initiate broad planning for nursing education on statewide, regional, and national bases.

Both books should be welcomed by consumers of nursing services, by co-workers with nursing in the health and medical care program, and by nurses themselves who are planning for the future. For those who are interested in education for nursing service the Brown report will be found the more pertinent. For those who wish a more detailed con-

sideration of the nursing problem the Brown report will also offer the more satisfactory reading. For those who lack access to nursing publications the documentations of the Brown report will prove helpful.

These two books appeared at a critical moment in nursing history. The aims of each are consistent with the problems of the day and the predicted needs of the future. Critical reading of these books should give insight into the complications to be anticipated as nursing moves into the future.

—Ruth Sleeper, *R.N., M.A., Director of the School of Nursing and Nursing Service, Massachusetts General Hospital, Boston.*

TRANSFERENCE IN CASEWORK

By Richard Sterba, Benjamin H. Lyndon, and Anna Katz. New York, Family Service Association of America, 1948. 51 pp. 75c.

The nursing profession, like other professions which come in close contact with people, utilizes information about human emotions. Such information tends to increase nurses' understanding of the interplay between physical and emotional factors in the patient's makeup.

Although primarily geared to social caseworkers, this pamphlet is useful to all who enter into close professional contact with client or patient. It is the product of the cooperation which has proven so fruitful in clinical settings between a psychoanalyst and two social workers. It brings together valuable information and clarifies the meaning of transference for the case worker.

Dr. Sterba is to be commended for pointing out the abuses of the term transference and for insisting on its exact use. Transference, according to him, is not synonymous with relationship but should be used only with reference to the "repetition of the emotional relationship to an object that was significant to us in our past." He points out that "there is hardly any important emotional relationship in which a considerable amount of transference from earlier objects does not participate." It follows, therefore, that the psychoanalytic concept of transference is applicable not only in the doctor-patient situation but obtains also in the client-worker relationship or any other relationship created for the purpose of professional service, although the goals of case work treatment are not to be equated with those of psychoanalytic therapy.

Professor Lyndon traces the development of casework from a benevolent process to one of client-worker participation. He focuses not only on the client's but also on the worker's personality, stressing the need for the worker's awareness of her own emotional make-up. He explores the meaning of transference in diagnosis and treatment. Like Dr. Sterba, he differentiates between the relationship and that part of it which is transference. "A casework relationship is the professional meeting of two persons for the purpose of assisting one of them, the client, to make a better, a more acceptable adjustment to a personal problem. The relationship is the sum total of all that happens between the participants—all the words exchanged, the feelings, attitudes and thoughts expressed; everything, in fact, that the client and worker do whether open or overt or devious and hidden."

Emotions occur in the relationship "whose source is not in the present relationship but is traceable to the past experience of the client and the worker." They are called transference, as long as the emotions emanate from the client. When they emanate from the worker and are transferred on to the client from her, we are faced with the phenomenon of counter-transference. Counter-transference has to be reckoned with as much as transference in the diagnostic and treatment aspects of the relationship. Recognition of these feelings of transference will help the worker to develop an objective attitude so that she can avoid emotional involvement in her client's problems. Miss Katz, in her case study, points out the technics used in handling the transference feelings with a client by the process of providing insight.

By throwing light on one important aspect of relationship this study has rendered service not only to social casework but to all professions involving human intercourse.

—Werner Boehm, *Assistant Professor, Department of Social Work, The University of Wisconsin.*

TECHNIQUE OF TREATMENT FOR THE CEREBRAL PALSY CHILD

By Paula F. Egel. St. Louis, C. V. Mosby, 1948. 201 p. $3.50.

This book aims to present the currently held opinions of Dr. Winthrop M. Phelps, substantiated by the author's clinical experience, regarding the treatment of cerebral palsied children. Emphasis is placed on management of the characteristic motor disabilities. This reviewer believes that in an attempt to simplify descriptions of technics used in caring for the cerebral palsied child, too many scientifically incorrect statements have been made and are in need of interpretation. One example is the author's statement on page 24 regarding muscle analysis "that it (muscle analysis or testing) is done by asking the child to move voluntarily all the muscles in the body, one at a time."

The book leaves much to be desired by those who respect accuracy, precision of thought, clear organization of material and, issuing from these, directives that are both possible of performance and therapeutically sound. However, to the less critical reader, the volume will serve to reemphasize some of the problems peculiar to the cerebral palsied and to outline in book form one well known approach to physical treatment.

—Elizabeth C. Addoms, *Technical Director in Physical Therapy, School of Education, New York University.*

GENERAL

Instruments, Laboratory Specialties and Teaching Aids for the Medical and Allied Sciences. New York, Clay-Adams Company, Inc. 1949. 164 p.

The products described in this catalog are available at all reputable surgical or laboratory supply dealers.

Homeless Men in New York City. Report of the Project Committee on Homeless Men of the Welfare Council of New York City, 44 E. 23 Street, N. Y. 1949. 43 p. 50c.

An Introduction To Chemical Science. By William H. Hatcher. 2nd edition. New York, John Wiley & Sons, Inc. 1949. 449 p. $4.00.

Microbes Militant: A Challenge To Man. By Frederick Eberson. Revised edition. New York, The Ronald Press Co. 1948. 401 p. $4.50.

Viral and Rickettsial Infections of Man. Edited by Thomas M. Rivers. New York, J. B. Lippincott. 1948. 587 p. $5.00.

CHILD WELFARE

Oklahoma's Problem Children. By Mike Gorman. The Oklahoma Committee for Mental Hygiene, 212½ N.W. 5, Oklahoma City. 1948. 32 p. 20c.

A compilation of the series of articles which the author wrote on child welfare problems in the state of Oklahoma.

Working With Parents. By Hazel F. Gabbard. 46 p. Bulletin 1948, No. 7. Federal Security Agency, Office of Education, Washington 25, D.C. 15c.

Comics, Radio, Movies—and Children. By Josette Frank. 32 p. No. 148. 1949. 20c. Public Affairs Committee, Inc., 22 East 38 Street, New York 15, N. Y.

RECREATION

The Field of Recreation. By Walter L. Stone. New York, William-Frederick Press. 1949. 41 p. $1.00.

LABOR

Working Women's Budgets in Twelve States. Bulletin No. 226. 1948. 36 p. 15c.

Women's Occupations Through Seven Decades. Janet M. Hooks. Bulletin No. 218. 1947. 260 p. 45c.

Handbook of Facts on Women Workers. Bulletin No. 225. 1948. 79 p. 25c.

For a limited time each of the above is available free from the Women's Bureau, U. S. Department of Labor, Washington 25, D.C.

NUTRITION

Mayo Clinic Diet Manual. By the Committee on Dietetics of the Mayo Clinic. Philadelphia. W. B. Saunders. 1949. 329 p. $4.00.

A Manual for Teaching Dietetics To Student Nurses. American Dietetic Association. Consultants: National League of Nursing Education. Philadelphia, W. B. Saunders, 1949. 487 p. $4.25.

Helping Families Plan Food Budgets. Bureau of Human Nutrition and Home Economics, U. S. Department of Agriculture. 1948. 16 p. 15c. Available from the Superintendent of Documents, Washington 25, D.C.

A semi-technical bulletin for nutrition leaders and teachers, especially for those who sit down with families and help work out plans to suit individual needs.

PRACTICAL NURSING

Attendant or Practical Nursing. By Katharine Shepard. 3rd edition. New York, The Macmillan Company. 1948. 506 p. $4.25.

FROM NOPHN HEADQUARTERS

CHANGES IN UNIFORM POLICIES

More "local option" in the national uniform will be the result of decisions voted at a meeting of the NOPHN Uniform Committee, March 29. This change was made following a brief review of the history of the present uniform policy.

It was pointed out that when the uniform was first inaugurated in 1946 it was agreed to ask the larger companies already making uniforms for public health nurses to take part in developing the new, official one. Four companies agreed to do this. They have, therefore, submitted samples of garments made according to the NOPHN style and in material chosen by the national committee, to the committee for approval before offering them to local agencies. The result has been that though the uniform style has proven popular throughout the country, the following difficulties have arisen:

1. Over 40 requests have been received from nursing agencies for approval of local concerns as manufacturers of the national uniform. It would, obviously, be impossible for the national committee to retain its present close supervision over all these. At the same time, it seems unfair to deny the local agency the right to have the national uniform made by a concern in their own community or by any company they wish.

2. Some of the materials chosen by the national committee have not proven equally suitable for the varying needs of nurses in local agencies and the widely differing climates in which they work.

3. Because a large committee cannot meet often there have been unavoidably long delays in acting upon requests for the approval of new manufacturers and new materials.

4. There have been variations in style details between various companies.

Some members of the Uniform Committee pointed out that in military and in other nursing services where complete standardization is attained, manufacture of the uniform is restricted to one company which is required to fulfill specifications set forth in contract form. Even so, a large and specially trained staff is required at national headquarters to see that specifications are met. They expressed the opinion that since NOPHN, with its limited staff, has found it difficult to maintain control of materials and manufacturing with the four companies under the present system, the situation would be completely impossible if the number of companies was increased.

It was, therefore, voted that:

1. In the future, NOPHN will ask local agencies to be responsible for the choice of materials used in the national uniform. NOPHN will, however, continue to supervise style and color.

2. In order to make the uniform readily available to agencies throughout the country, NOPHN will

a. Ask local agencies to assume responsibility for selection of manufacturers.

b. Have drawn up as soon as possible specifications for and designer's sketches of the various NOPHN uniforms. These will be sent, upon request, to local agencies and will be accompanied by a swatch of material to indicate the proper color.

c. Ask local agencies to see that specifications are met to their satisfaction.

Mrs. Edith d'Errecalde, who designed the uniform, generously offered to prepare the specifications. Work will begin at once, starting with the poplin dress, but as it may take months to complete the specifications, agencies are requested not to ask for them until an announcement that they are ready.

It was stressed that the Uniform Committee will continue to see that the standard uniform style is in keeping both with current fashion

trends and the particular needs of public health nurses.

Since there have been several suggestions as to possible changes in the box coat, a subcommittee of six was given authority to alter its specifications.

As only one company continues to make the blouse, it was decided that nurses be advised to purchase "any plain, white, tailored blouse with either a round neck or a convertible, shirtmaker type collar, approved by their agency."

As to hats, the specification will read: "We suggest the snapbrim hat now made by McHenry's or one similar to it in felt or in straw; the overseas cap in use at present; or any well made beret the agency may choose. Whatever type of headgear is used should match the color of the coat, suit or dress with which it will be worn."

At the close of the meeting Mrs. Hatton, chairman, expressed for the committee and all members of NOPHN appreciation to Mrs. d'Errecalde for her gift of her talents and time in order that every public health nurse might have a uniform which adds to her pride in her profession and her pleasure in being a woman.

Attending the meeting were: Mrs. Mildred L. Hatton, R.N., Providence District Nursing Association; Mrs. Frances Osborn, R.N., Detroit Department of Health; Florence Austin, R.N., Visiting Nurse Association of Brooklyn; Mrs. Edith d'Errecalde, (designer) of New York; Mrs. C. Edwin Ireland, Swarthmore, Pennsylvania; Kathryn Robeson, R.N., Visiting Nurse Service of New York; Mrs. Hubert S. Russell, Scarsdale, New York; Mrs. Philip A. Salmon, Short Hills, New Jersey; Mrs. William Simpson, Fairfield, Connecticut; Anna Fillmore, R.N., General Director NOPHN; Mrs. Helen Nelson, Secretary of the Uniform Committee.

AWARD TO MISS HUBBARD

A Bronze Medal for Distinguished Service to Nursing during 1948 was awarded to Ruth W. Hubbard, president of the NOPHN, and general director of the Visiting Nurse Society of Philadelphia, on March 24, at a ceremony at 311 S. Juniper Street, Philadelphia, by District 1, Pennsylvania State Nurses' Association. The medal, first of its kind, was awarded Miss Hubbard for her overall contributions to nursing and nursing service during the past year.

Presentation of the medal was made by Ralph Kelly, president of the Philadelphia Chamber of Commerce, and chairman of the Hospital Planning Agency of Philadelphia. The winning citation reads in part: "Miss Hubbard has given many extra hours each day to be able to carry her regular position and to give thoughtful help to the many committees of which she is a member. She has been a leading spirit in initiating ideas in these committees."

Among her many committee memberships are the Executive Committee of the Philadelphia Health Survey; chairman of the Health Group, Social and Health Agencies Division of the Community Chest; member of the board of the Philadelphia League of Nursing Education, and the board of the Philadelphia and Camden Social Service Exchange; member of the Nursing Advisory Committee and chairman of the Public Health Nursing Advisory Committee at the University of Pennsylvania. She is at present on the teaching staff of the University.

Miss Hubbard has been prominent in the development of the "Intensive Home Care Plan" for long-term illness which will soon be initiated in Germantown. Sponsored by the VNS, in conjunction with the Starr Centre Association of Germantown, the plan will make available for chronically ill patients in Germantown a broad service never before available in their homes. It will include medical service, nursing care, physical and occupational therapy, mental hygiene and nutrition services, housekeeper service, and the full health and welfare resources of the city of Philadelphia. This service will demonstrate its value in Germantown, with a view to extending it later on.

The Bronze Medal is the district award made by the Pennsylvania State Nurses' Association. Winners of the Bronze Medal in each of the eight association districts will be eligible for the Gold Medal award. This highest award will be presented this Spring

for "distinguished service to nursing in Pennsylvania during 1948," together with a citation and scroll. Representatives of medical, hospital, nursing and lay groups have been asked to serve on the statewide panel of judges so that an impartial decision, reflecting community reaction, can be reached.

Nominations of nurses for the district awards were submitted by doctors, nurses, and women's clubs. Each winner was chosen by a panel of judges associated with outstanding community organizations in their district.

This is the first professional award of its kind in the United States to be given annually to a nurse for current achievement.

STRUCTURE INSTITUTE IN CHICAGO

The institute for leaders of discussion on the structure of organized nursing, held at The Stevens, Chicago, March 18 and 19, brought together 112 representatives from 44 states and the District of Columbia to talk over the two 1949 plans with the six members of the Committee on the Structure of National Nursing Organizations who served as the panel of experts. The purpose of the meeting was to study methods of conducting discussion on material in the new 1949 Handbook rather than to reach any decision about plans presented in it.

Hortense Hilbert, chairman of the Committee on Structure, chaired the 2-day institute. Serving as discussants with her were committee members, Stella Goostray, Alma C. Haupt, Elizabeth Hilborn, Louise Knapp, and Helen C. Schwarz.

It was an industrious and appreciative gathering. The state leaders were warm in their praise for the work of the Committee on Structure, for the leadership given at the Chicago meeting, and for the new clarity that they felt the 1949 Handbook brought to the structure program. And they asked penetrating questions. These questions, with answers or related discussion materials, are being published in an April News Letter of the Committee on Structure as a further aid to state and local discussion groups.

As a result of Chicago discussion, a change is being made in procedure. Opinionnaires are to be returned, not to the different organizations, as asked in the Handbook, but to the Committee on Structure, Room 209, 250 West 57th Street, New York City 19.

State structure committee chairmen asked the change, pointing out that since state and local discussion groups are to be representative of all organizations, the opinions reached will represent thinking of all nurses in the particular area rather than thinking of an organization group.

Any individual or group wishing to send an opinion directly to any one of the six organizations participating in the structure study may, of course, do so. And it still remains true that "each of the six existing national nursing organizations will need to make its own independent decision in order to take the leap from the present into some possible future, different status," as the Handbook states.

After consultation with the sponsoring organizations, it has been decided to ask that opinionnaires be returned *as early as thorough consideration of the two plans proposed in the Handbook will permit, but no later than December 1, 1949.*

Obviously early returns are necessary if the profession wants detailed plans ready for consideration at the 1950 Biennial. It is hoped that some states can discuss the proposals thoroughly and return their opinionnaires this spring or early summer.

Where it is necessary (in order to form considered opinions) to continue the structure discussion program through an autumn convention of a state organization, the Committee on Structure urges that every effort be made to return the opinionnaires immediately after such convention. If, as scarcely seems likely, a convention date should be so late as to make it physically impossible to get a return back to the Committee by December 1, every effort will be made to give it consideration in the summing up.

Single copies of the Handbook and the April News Letter may be had free on request to the Committee on Structure, and every effort will be made to fill requests for quantities if the use to which the materials are to be put is stated. However, the Committee on Structure urges persons wishing a Handbook

to clear with leaders of groups with which they are affiliated before writing to the Committee, as some areas may already have the "one Handbook to ten nurses," which was the basis for the distribution plan. Supplies are limited. Circulation and intensive use of each Handbook will, therefore, be appreciated.

MONTHLY REPORT FORM

An NOPHN monthly report blank may now be bought from Mead and Wheeler of Chicago. It is a tentative form which we hope will be useful to agencies that have written for such help.

NOPHN FIELD SCHEDULE

Staff Member	*Place and Date*
Anna Fillmore	Chapel Hill, N. C.—May 2-4
	Philadelphia, Pa.—May 11
	Buffalo, N. Y.—May 24
Lucy E. Blair	Philadelphia, Pa.—May 3-5
	Roanoke, Va.—May 9-14
Hedwig Cohen	Orange, N. J.—May 10
	Bernardsville, N. J.—May 17
M. Olwen Davies	Cleveland, O.—May 2-5
	Washington, D. C.—May 6, 7
Ruth Fisher	Lancaster, Pa.—May 9
	Richmond, Va.—May 10-12
Jean South	Detroit, Mich.—May 2-6
Louise M. Suchomel	California—May 1-13
Marie Swanson	Danbury, Conn.—May 10
	New Haven, Conn.—May 11
	Hartford, Conn.—May 12

In addition to field trips previously announced, Anna Fillmore visited Providence, R.I., in April, and Hedwig Cohen, Washington, D. C.

ABOUT PEOPLE WE KNOW

The Leslie Dana Gold Medal for 1948 for "outstanding achievement in the prevention of blindness and the conservation of vision" was presented on March 25 to *Dr. Lawrence T. Post* of St. Louis. . . . Two retirements have been announced: *Mrs. Margaret P. Momberg*, after 22 years of active service as a public health nurse in Minnesota and Nebraska, and *Mrs. Charlotte B. Oderkirk*, executive secretary of the Oklahoma SNA for 13 years and a staff member of the Tulsa City School Health Department for 14 years. . . . The following appointments have been received: *Mrs. Gladys Jacoby Wilson*, chief public health nurse for the Bureau of Constructive Health of New Jersey, and *Caroline E. Kinney*, nurse consultant in Mental Hygiene, Kansas State Board of Health. . . . *Anna Teresa Fallon* assumed her duties as an orthopedic consultant with NLNE and JONAS March 20. . . . *Marie Grant* has accepted a position in Fairbanks, Alaska. . . . *Miriam A. Dailey* has been appointed director of the Montclair Public Health Nursing Service. She succeeds *Anna C. Gring* who has accepted a position on the faculty of Boston University.

Julia Jane Hereford was appointed associate dean of the School of Nursing, Vanderbilt University, February 7, and will assume the office of Dean on July 1. She will replace *Frances Helen Zeigler* who will retire from professional life. . . . *Dorothy Doyle* of the State Department's Office of Inter-American Affairs has been assigned to duty in the Amazon Valley of Brazil for two years. She will teach nursing education and set up public health centers. Miss Doyle is a sister of Mabel Staupers, formerly executive secretary of NACGN. . . . *Ann E. Forsyth* has accepted a position with the U. S. Veterans Administration as chief nurse, and has been assigned to duty in the Philippines. . . . *Julia M. Anderson* has recently assumed duties as a general public health nursing consultant with the California State Department of Public Health. . . . *Lillie Young*, R.N., of Guilford, Vermont, has been recently elected to the Vermont House of Representatives. . . . *Anne Prochazka* is now in charge of a Visiting Nurse Center in Chicago as well as an instructor in Social Aspects of the Handicapped at Northwestern University. . . . *Dr. Jessie M. Bierman*, former member of JONAS' Council on Orthopedic Nursing, left for the American Zone of Germany in January to take part in a study of maternal and child health under the democratization program. . . . The Visiting Nurse Association of Brooklyn, N. Y., has announced two new appointments to their staff: *Mrs. Louise Fronville*, supervisor for the Flatbush office; and *Winifred McLanahan*, assistant supervisor in the Bay Ridge office. . . . *Earl James McGrath*, Ph.D., has been appointed Commissioner of Education.

NEWS AND VIEWS

FROM FAR AND NEAR

SCHOOL DATA SURVEY UNDER WAY

A nationwide survey of schools of nursing has been undertaken by the six national nursing organizations in order to provide a basis for gearing education facilities to meet the country's urgent nursing needs.

The survey is the first national inventory of nursing educational resources to cover all of the 1215 state-accredited schools of nursing. It will be conducted by the Joint Committee on Implementing The Brown Report. Chairman of the committee is Mary C. Connor, research associate of the Division of Nursing Education, Teachers College, Columbia University.

"The national survey will have immediate results," Miss Connor pointed out. "It will assess the nation's current nursing assets in terms of future needs. It will show which needs must be met first. It will assist in selective recruitment efforts, indicating where prospective students should be guided in the light of their individual abilities. It will make it possible to classify schools of nursing. And it will demonstrate what additional funds are necessary for nursing education."

Miss Connor pointed out that the present shortage of nurses is so acute that some hospitals have been compelled to close wards because they were unable to supply nursing service for the patient.

The number of students enrolling in schools of nursing is increasing again. In 1946 there were only 30,900 new students. About 43,000 were admitted this year. Miss Connor said the need for nurses continues to mount and stated that recent estimates indicate that at least 60,000 new students should be admitted in 1950 to meet minimum needs.

"The need for an increasing number of nurses may be attributed to a number of factors," Miss Connor said. "The role of the nurse in the prevention and treatment of disease and the protection of health is continually growing in importance. Growing consciousness by the general public of the importance of health care is resulting in increased use of hospitals. Public health services are expanding and are extending into communities which have never had such services. Nursing needs of the armed forces and the Veterans Administration continue at a high level. The many new hospitals being built will each need a staff of nurses."

Deadline for return of questionnaires sent to all nursing schools was March 10. The survey is to be completed by June 30.

STUDENT NURSES TO BE HONORED

Churches together with medical and hospital associations will salute nursing in a nationwide observance, Sunday, May 15, following National Hospital Day, May 12, which is also Florence Nightingale's birthday. Jewish groups will observe May 14. Throughout the country, attention will be focused on senior students in schools of nursing.

Assisting in the planning of American Student Nurse Sunday are the nursing services of Public Health Service, Veterans Administration and the Armed Forces, according to Theresa I. Lynch, chairman of the Committee on Careers in Nursing. Local recruitment groups, schools of nursing, and officers of state nursing organizations are joining forces with the other groups in honoring the senior nursing students at church services and other special events during the day and week. High school students are to be invited to church services and open houses.

Although it has been customary in past years to focus attention on nursing as part of the celebration of National Hospital Day, Miss Lynch stated that the program is re-

ceiving additional impetus this year through the cooperative efforts of national organizations as well as their local units. National radio programs, both church and special features, are scheduled as part of the observance.

The Federal Council of Churches of Christ in America, the Catholic organizations and the Synagogue Council of America, as well as the chaplains of the Army, Navy and Veterans Administration, will feature the nursing profession and its contribution to the national economy in the past and in the future.

As part of the special observance, senior students will be asked to complete a questionnaire, showing both their immediate and future interests in fields of nursing, as well as whether they are planning to accept a reserve commission in one of the armed services for service during a national emergency. News releases on the information received will aid in informing the public about the many opportunities in nursing as well as indicate the preferences of students for the various fields of nursing.

RADIO PORTRAYS NACGN HISTORY

On April 9 the National Broadcasting Company presented a Public Affairs program entitled "Brown Women in White." The script portrayed in dramatic form the story of the National Association of Colored Graduate Nurses, as told to two patients in an interracial hospital, one of whom had never seen a Negro nurse, by a staff nurse on the ward where the injured men were hospitalized. The white patient left the hospital with high praise of the smooth intergroup relationships he observed. He was also grateful to his nurse for telling him something about the problems and progress of Negro nurses. It was written by Mr. Jack Caldwell, outstanding young Negro writer who created and produced the "Harlem, U. S. A." scripts for a period of 13 weeks on Station WMCA, New York City.

Alma Vessells, executive secretary of the NACGN was cast in the role of "Miss Robinson," nurse who cared for the two patients.

MAY PLENTIFULS

The foods listed below are expected by the U. S. Department of Agriculture to be in plentiful supply throughout the greater part of the United States during May 1949. To qualify for the list, items must be commonly used and generally available. These plentiful foods usually offer consumers more for their dollar than alternative foods that are less plentiful. They suggest "features" for menus, recipes, and discussion of food selection.

Naturally, supply and price conditions vary from place to place. Those who work with a localized audience are advised to check local markets before featuring these foods.

Vegetables: Carrots, Irish potatoes, Spinach (Northeastern area) Canned corn, Canned peas, (lower grades) Dried beans and peas.

Fruits: Canned citrus juices, Canned grapefruit sections, Dried prunes, Raisins.

Other Foods: Eggs, Broilers and fryers (east of the Mississippi). Fish (fresh and frozen), Processed dairy products, Oatmeal, Corn products, Honey, Peanut butter.

It is recommended that special emphasis be given to eggs.

● Wayne University College of Nursing has available in each academic year eight scholarships for graduate nurses who wish to improve their preparation in maternal and child care nursing. Preference is given to nurses preparing for positions as instructors or supervisors in pediatric and obstetrical nursing and to public health nurses who have special positions which will utilize this preparation. The program includes the professional major towards the degree of Bachelor of Science in Nursing.

The scholarships include payment of all university fees for two semesters and a maintenance allowance of $125 a month over the academic year.

Nurses desiring further information should write the Dean, College of Nursing, Wayne University, 5257 Cass Avenue, Detroit 2. In their letter they should give in detail an account of their previous education and experience and why they wish this advanced preparation.

● The U. S. Civil Service Commission has announced that the closing date for applications for examinations for the position of public health nurse at $3,727 and $4,479 a year, has been extended from March 29, 1949 to June 30, 1949. For further information see PUBLIC HEALTH NURSING, February 1949, p. 86.

● The 8th annual conference of the National Association for Practical Nurse Education will be held on May 16, 17 and 18, 1949 at the Hotel Statler, New York City.

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*For full details see "Comparative Cost and Availability of Canned, Glassed, Frozen, and Fresh Fruits and Vegetables" in the April, 1948, issue of the *Journal of the American Dietetic Association.*

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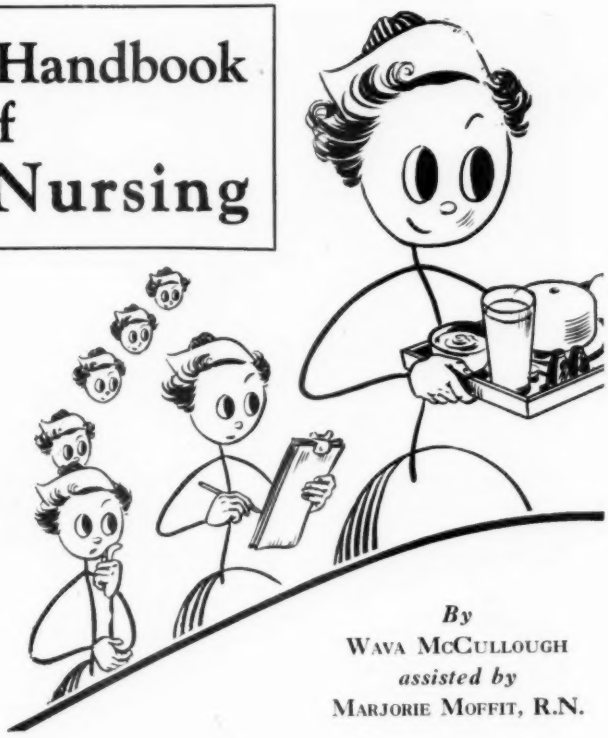

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*Meyer, K. A., and Kozoll, D.D.: Progress in the Treatment of Carcinoma of the Stomach and Esophagus, South Dakota J. Med. & Pharm. *2*:39 (Feb.) 1949.

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WANTED—Educational Director. Private organization; generalized program; graduate affiliation with university program. Degree and background in supervision required. Staff of 25 nurses; 40 hour, five day week; annual vacation 20 working days; sick leave; retirement plan. Write: Executive Director, Instructive VNA, 223 South Cherry Street, Richmond 20, Va.

WANTED—Registered nurse for small private boys' camp; south-central Wisconsin; scenic, good facilities, near hospital. Write: Mrs. M. O. Garland, 2888 Sheridan Place, Evanston, Illinois.

OPPORTUNITY for supervised field experience for staff nurses in comprehensive public health nursing program, including care of the sick, maternity, infancy, preschool, and tuberculosis supervision. Consultant service provided in mental hygiene, maternity and child health, tuberculosis, and nutrition. Cooperative relationships with community agencies and the public health, medical, and nursing programs of Yale University. Full qualifications call for—college education, strong school of nursing background, and desirably, program of study in public health nursing. Salary scale $2,600-$3,080. Minimum requirements—one year of college, plus strong school of nursing; salary scale $2,400-$2,760. For further information write: Miss Elizabeth G. Fox, Executive Director, Visiting Nurse Association, 35 Elm Street, New Haven 10, Connecticut.

WANTED—Qualified public health nurses. Generalized service; population 200,000; rural and urban. Beginning salary $3,120 plus $180 cost of living increase; retirement plan, five day week; cars furnished. Must be eligible for California P.H.N. certificate and registration. Apply: Mrs. Mary D. Chamberlain, Director of Public Health Nursing Service, San Joaquin Local Health District, Stockton, California.

WANTED—Public health nurse in teaching center. Generalized program. Salary depends on education and experience. Write: T. W. Mahoney, Health Commissioner, Lucas County Health Department, 902 Adams Street, Toledo, Ohio.

WANTED—Supervisor for staff of 15 nurses; private organization; bedside care and maternity service; salary based on experience, 40 hour week; vacation with pay; sick leave; retirement plan. Requirements: thorough field experience; 1 year of postgraduate study; some knowledge of supervision. Opportunity for advancement. Write: Visiting Nurse Association, 316 Elizabeth Street, Utica 3, New York

WANTED—Public Health Nurses for overseas service. Require supervisory or organizational experience to develop maternal, infant and child care projects and organize small hospitals and dispensaries as well as develop overall public health program. Speaking knowledge Yiddish or French essential. Beginning salary $4,000 with yearly increments in addition to living cost allowance. Contact: Robert Pilpel, Secretary, Medical and Health Committee, American Joint Distribution Committee, 270 Madison Avenue, New York 16, N. Y.

WANTED—Two staff nurses for generalized public health nursing program; adjacent Washington, D.C.; three weeks paid vacation; sick leave; 40 hour week, merit salary increases, opportunity to attend universities part-time in Washington. Must own car. Apply: Personnel Director, Arlington Court House, Arlington, Va.

WANTED—Public health nurses for generalized nursing program; salary range $265-$285 per month; 40 hour week; vacation and sick leave privileges; car furnished. Write: Director of Public Health Nursing, 504 County-City Building, Seattle 4, Washington.

WANTED—Public health nurses for positions on all levels in urban and rural agencies, official and private, in various parts of the country. No fee. Apply in person or write to Nurse Counseling and Placement Office, New York State Employment Service, 119 West 57th Street, New York 19, N. Y.

WANTED—Immediately—Assistant director in Education for long established, well endowed, community chest affiliated public health nursing agency in central Massachusetts. Population 200,000. Highly industrial yet progressive community with active cultural and civic advantages. Easy access to Boston and New York via rail, bus, plane. Help offered in finding living quarters. Staff of 35—3 supervisors, 2 administrators; generalized service including orthopedics and child health; graduate student program. Retirement plan in operation. Applicant must have full qualifications recommended by NOPHN for stated position; salary not less than $4,000. State full particulars of preparation and experience. Apply: Miss Ella Pensinger, Director, Worcester Society for District Nursing, Inc., 2 State Street, Worcester 8, Mass.

WANTED—Public health nurse for generalized program including school service. Staff of 40 nurses. Completion of accredited course in public health nursing required. County car or 7c per mile for personal car. Beginning salary $2,940 per annum. Merit system, five day week, good personnel policies.

Well qualified physician. Training and experience in public health required. County car or 7c per mile for personal car. Beginning salary $5,700 per annum, maximum salary $7,140 per annum. Merit system, 40 hour week, good personnel policies.

Public health laboratory technician. Opening in a modern, well-equipped laboratory requiring professional training and experience. Staff of 12 technicians under direction of M.D. Entrance salary $3,540 per annum. Merit system, 40 hour week, good personnel policies. Interested candidates write: Kern County Personnel Department, Room 108 Court House, Bakersfield, California.

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